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A Systems View of Early Interventions for Vicarious Trauma:

Managing Secondary Trauma Stress

by

Kelly A. Berscheit, BS, LSW

MSW Clinical Research Paper

Presented to the Faculty of the School of Social Work St. Catherine University and the

University of St. Thomas St. Paul, Minnesota

In Partial Fulfillment of the Requirements of the Degree of

Master of Social Work

Committee Members

Dr. Felicia Washington Sy, MSW, Ph.D., LICSW (Chair)

Mikki J. Rothbauer, MSW, LICSW

Shari Kottke, MSW, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

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Abstract

A Systems View of Early Interventions for Vicarious Trauma:

Managing Secondary Trauma Stress

by Kelly A. Berscheit

Research Chair: Dr. Felicia Sy, Ph.D, MSW, LICSW

Committee Members: Mikki J. Rothbauer, MSW, LICSW; Shari Kottke, MSW, LICSW

This is a heuristic study of the current prevention and intervention efforts of clinical social workers working with traumatized clients. The purpose of the research was to identify the best mechanisms of prevention and interventions for secondary trauma stress (STS) and vicarious trauma (VT) to develop a systems protocol to shield therapists from the impact of working with traumatized clients. The data was collected through interviews with eight practicing licensed clinical social workers. Findings in this study suggest STS is normal and to be expected if working with traumatized clients and that VT may be prevented. The results of this study indicate that these trauma therapists identified trauma informed clinical supervisors as the most effective intervention, along with consistently practicing an individually determined self-care regime for protection from STS and VT. This study supports the importance of a trauma care system that has a 'culture' that is aware, recognizes and normalizes STS and VT. This research project highlights that it is not the sole responsibility of the trauma therapist to bear the burden of helping traumatized clients but the entire system must work as a team to support the trauma therapist which parallels effective quality services for the client.

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A Systems View of Early Interventions for Vicarious Trauma:

Managing Secondary Trauma Stress

Trauma therapists are vulnerable to secondary trauma stress (STS) also often referred to as vicarious trauma (VT). Therefore, it may be necessary that the trauma clinician, their supervisor, and their employing organization develop a formal plan to prevent or effectively intervene if a therapist is experiencing symptoms of STS or VT. According to Culver, McKinney, and Paradise (2009), clinicians who worked with trauma reported many negative psychological symptoms including anxiety (73%), suspiciousness (62%), disrupted sense of safety (71%) and disrupted frame of reference (50%). Therapists are human and may experience traumatic loss and grief (Boss, 2006). STS and VT for a therapist can be caused by trauma events such as the sudden death of a client including suicide, listening to the client's story of violent assaults such as rape, murder, and torture or working with survivors of disfiguring accidents, terrorism such as 9/11, or natural disasters such as Hurricane Katrina. Perlman (1999) explains that a trauma therapist must carry the burden of the trauma with the client in the midst of trauma therapy. The burden of trauma and secondary stress when working with traumatized clients can impact multiple facets of the clinician's life; their behavior, emotions, relationships, beliefs, success and health.

STS and VT may be considered an occupational hazard for the trauma clinician. For 30 years, researchers and practitioners have been concerned about the impact of work stress experienced by social workers (Bell, Kulkarni, & Dalton, 2003). STS and VT can impair the skills of the clinician and negatively impact the therapeutic relationship. The National Association of Social Work (NASW, 2008) ethics advises clinical social workers against impaired practice to prevent harm to the client and the profession. NASW (2008) endorses the

social worker seek help if impaired. Therefore, aside from the ethical importance of preventing harm to the client, without a STS and VT prevention and intervention plan for the trauma therapist, their license to practice, career and livelihood may be at risk.

Our nation has identified trauma as a public health concern and highlighted the importance of vigorous trauma interventionists. In 2011 our federal government, specifically SAMHSA, recognized the impact of trauma on the community, including those working with trauma, and the need for support and interventions for all first responders. Clinical social workers working with trauma clients are included as first responders. The United States government suggests that making high quality services available to individuals and families affected by trauma requires a workforce with the training, skills, capacity, and commitment crucial to providing effective care (NCTSN, 2008).

A formal plan to prevent STS and VT along with diligent systemic support to act on the plan when necessary may benefit the client, therapist, service delivery. A formal prevention plan may contribute to an overall positive functioning of the organization where they work. Clinician self-care, supportive supervision, organizational policies, and training that endorse recognition, prevention, and intervention of STS and VT may be vital to the preservation of the trauma therapist, quality client services, and the social work profession.

Attending to the bio-psycho-social and spiritual welfare of social work clinicians working with trauma is imperative. Therefore, this qualitative study is to investigate the current practices of prevention and intervention of STS and VT among clinical social workers working with trauma. There are two aims of this research. The first is to determine if clinical social workers working with trauma are aware of STS and VT and practicing prevention or accessing interventions. The other goal of this research is to identify the effective means to protect and

maintain the passion, skills, health, and longevity of clinician social workers who pursued a career in trauma work.

Definitions

The following definitions were gathered from a review of the literature. It is important to be clear on the definition and differences of secondary trauma stress (STS) and vicarious trauma (VT) and to note that neither are a disorder. This study concedes that secondary trauma stress reaction is a universal phenomenon. Additionally, the symptoms of VT are amenable to reduction by prevention and may be intercepted by each ecological system working with trauma.

Secondary Trauma Stress

The definition of secondary trauma stress (STS) is the direct result of hearing emotionally shocking material from traumatized clients with symptoms of intrusive imagery, avoidant behaviors, a heightened arousal state, general distrust of others, and general anxiety. Symptoms lasting less than one month are normal, acute, and crisis related reactions (Canfield, 2003).

Vicarious Trauma

Vicarious trauma or vicarious traumatization (VT) has also been referred by researchers as contact victimization, secondary traumatic stress, compassion fatigue, secondary wounding, and event countertransference. VT is defined as a pervasive effect on the identity, world-view, psychological needs, beliefs, and memory systems of a therapist who treat trauma survivors. VT is different from countertransference because countertransference is temporary (Canfield, 2005; Culver et al., 2009; Lonergan, O'Halloran, & Crane, 2004; Sommer, 2008). VT is "neither a reflection of inadequacy on the part of the therapist nor of toxicity or badness on the part of the client" (Perlman, 1999, p. 52).

Secondary Trauma Stress Disorder

VT and STS are not the same as secondary trauma stress disorder. Secondary trauma stress disorder (STSD) is similar to post traumatic stress disorder (PTSD), but the therapist did not witness the trauma event. Unsuccessful integration of the client's trauma material results in STSD in which the therapist assumes the victim role, stops trying to integrate, and stops trying to survive the material. STS reaction symptoms that last longer than six months is considered STSD (Canfield, 2003).

Literature Review

This literature review takes an in depth look at secondary trauma stress (STS) and vicarious trauma (VT). The literature review demonstrates the need to prevent vicarious trauma from plaguing the counseling professions and most importantly preventing any harm to the client. The review concludes by stating that the trauma therapist, the supervisors of trauma therapists, and the trauma response employer need to address and prevent vicarious trauma to prevent vicarious trauma from becoming a disorder in the therapist.

Symptoms of Vicarious Trauma

Traumatic events affect the survivors and those of immediate relationship to the survivor as well as those in their secondary environments. Family members and counselors can experience trauma related symptoms (Sommer, 2008). Research indicates the VT symptoms look like PTSD symptoms. The symptoms most often mentioned are intrusive thoughts of a particular client stories, avoidance of related stimuli, dissociation, psychological numbing, hyper vigilance, and arousal (Canfield, 2003; Sommer, 2008). Studies found specific areas in the therapist life are disrupted by VT: lack of motivation, depression, hopelessness (Culver et al., 2011), beliefs around dependency, safety, control, self-esteem, and intimacy (Canfield, 2003). Strong reactions

to VT may include grief, rage, outrage, sorrow, a deep sense of loss; affect tolerance, fundamental psychological needs, internal imagery and body experiences (Canfield, 2005). VT can cause somatic reactions such as nausea, headaches, exhaustion, and visceral distress such as feelings of horror (Sommer, 2008). Sleep disturbances are linked to VT (Canfield, 2003). A therapist affected by VT may start to see other people as dangerous and threatening, evil, untrustworthy, unreliable, exploitative, controlling and or disconnected (Canfield, 2003). The spiritual beliefs of the trauma therapist impacted by VT may shift in meaning, along with their purpose in life and their sense of identity (Canfield, 2005).

Culver et al. (2011) used a mixed method research to examine the impact of VT in the mental health providers' professional and personal functioning post Hurricane Katrina. The study involved thirty clinicians who had provided direct care and five directors that provided clinical and administrative supervision of the clinicians at mental health agencies in the New Orleans region. Ninety-six percent of the clinicians reported working with one to twenty trauma victims a week. The most common types of trauma were domestic violence, childhood sexual abuse, physical assault, and natural disaster. The researchers found a significant association between the therapists working with trauma victims and the therapists' altered perception of self. The altered perception of self was significantly correlated with the clinicians experiencing negative psychological effects.

STS can impact a therapist's critical thinking skills. Child Protection (CP) workers with higher levels of traumatic stress symptoms were less likely to identify risk factors in cases. The symptoms of avoidance, reactivity, and diminished critical thinking skills were common; therefore, CP workers were less likely to effectively intervene for their clients (ACS-NYU Children's Trauma Institute, 2012).

Furthermore, personal and work place stress can contribute to the vulnerability to STS (Canfield, 2003). Symptoms of VT at work may look like disrespecting clients, disrespecting work. The clinician experience STS or VT may make more mistakes, lack energy, use work to block out happiness, pain, discontent, and loss of interest. VT may be a contributing source to a sense of powerlessness and incompetence (Williams, Promarantz, Segrist, & Pettibone, 2010) .

The Burden of Trauma Therapy

The word burden has a spiritual meaning as found in the Bible, a physiological meaning of weight, and a social meaning of responsibility. In therapy, the word burden has a psychological meaning. The *Collins Concise English Dictionary* (2013) defines psychological burden as something that is carried emotionally, that is emotionally difficult to bear, and a great source of worry and stress. Perlman (1999) explains trauma work requires the therapist to carry the burden for the client. In the second stage of trauma treatment, the clinician must take in, manage, and bear witness to be the functioning tool for the client. This requires the clinician to immerse themselves in the client's world of pain which may trigger the clinician's own personal experiences. The patient needs the therapist to be the anchor to transitionally make sense and reconstruct a new way.

Berscheit (2012) revealed that a Chaplain, even after numerous trauma debriefings, still identified the ashes of grief and loss. His quote described the impact of working with trauma over time: "Yeah, it does take a piece of you when you are carrying others burdens so they can bear the burden they [client] have to bear," [to deal with the trauma]. In addition, the federal Substance Abuse Mental Health Association (SAMHSA, 2012) also reports that the effects of trauma places a heavy burden on individuals, families, communities and challenges the public institutions and services systems.

Secondary Trauma Stress is Unavoidable

In 2004 Trippany, White, Kress, and Wilcoxon (as cited by Sommer, 2008) discussed the prevalence of traumatic events, stating that counselors in virtually all settings will work with clients who are survivors of trauma. Many therapists experience normal reactions to trauma material which manifests as STS (Canfield, 2003). Figley (as cited in Lawson & Myers, 2010) determined for the trauma therapist the cost and risk of caring is VT while the benefit is compassion satisfaction. Meldrum, King, and Spooner's research in 2002 (as cited in Sommer, 2008) found that 18% of general mental health workers regardless of settings or client population, "are experiencing symptoms which in quantity, quality, and intensity are equivalent to those experienced by people who meet criteria for diagnosis of PTSD". Canfield (2003) conducted an exploratory qualitative study of STS and VT among 15 trauma therapists working with children. One hundred percent of the trauma therapists reported STS reactions. VT, operationalized in the study as negative perceptual shifts, was reported by less than one third, with zero reporting chronic STSD.

Lastly, Canfield (2005) reviewed numerous quantitative and qualitative studies that confirm the impact of vicarious trauma on therapist. Canfield concluded that VT will change the therapist as a person and as a therapist. Because of VT, the therapist will gain a new awareness of the preciousness of relationships and helpful interventions. The therapist can transform VT into healing experiences for themselves and their clients.

The skills, education, or experience of the trauma therapist cannot guarantee protection from VT. Good et al. (as cited in Williams et al., 2010) found that because of therapist's professional identity, they can begin to believe that as psychologists, they are healthy and others are troubled. Unfortunately, the truth is psychologists are vulnerable to the same troubling issues

as any other individual. In 2000, Weaks' research did not find any evidence that therapists with the most advanced degrees or more than ten years of experience are any less susceptible to VT (Canfield, 2003).

Skilled but not Informed

Clinical social workers have the skills to treat trauma. Clinical social work practice uses theory and methods to restore, maintain, and enhance the bio-psycho-social and spiritual functioning of individuals, groups, families, and communities (NASW, 2008). Trauma therapists have been trained to focus only on negative reactions, regardless how mild or extreme (Boss, 2006). Yet, therapists often enter the field of trauma therapy without a full understanding of the implications of VT (Canfield, 2003).

The first phase in development as a therapist is refining counseling skills; therefore, most report their initial work with traumatized clients resulted in the therapist feeling a lack of confidence and shock of the trauma story. The first encounter with trauma work can create visual imagery that most clinicians find psychologically and physically distressing (Canfield, 2005). This demonstrates the STS reactions when working with traumatized clients and lends to the possible evolution of VT.

Starts with Self-Awareness and Recognition of VT

A lack of self-awareness or recognition of the symptoms of VT is a risk for VT. Richards, Campenne, & Burke (2010) defined self-awareness as introspection and evaluation of one's thoughts, feelings, and behavior resulting in insight and clarity. Before there can be a change in behaviors related to caring for themselves, therapists must first develop awareness of the distress which involves the growing awareness of self (Lonergan, O'Halloran, Crane, 2004). Curran (2010) suggests that all professionals working with trauma should memorize and recognize the

functions of the somatic nervous system which is the conscious muscle control involving senses, and the autonomic nervous system which is an involuntary muscle control. When the client and therapist recognize the signs of hyper arousal or distress each will gain a sense of body awareness and a greater sense of self-knowledge and self-control.

It might be helpful to require the trauma therapist be aware and educated on VT, but also recognize STS and VT before treatment begins. Boss (2006) suggests that knowledge of VT, talking often about the effects of working with trauma, and identifying and sharing about the feelings associated with trauma work, can be useful steps to recognizing VT. If working with trauma affects the critical thinking of the therapist as found in the study of CP workers (ACS-NYU Children's Trauma Institute, 2012), then self-awareness may not be present. They need help recognizing the symptoms from others such as supervisors, colleagues, and co-workers.

Clinician's Responsibility

It is imperative that we preserve, restore, enhance, and value the primary tool of therapy, the clinician, to prevent harm to clients who are the victim of the actual trauma event. The clinician is the tool to help the client identify and work through the pain. It may be important for clinicians to recognize their absence of presence in the client's session such as preoccupation with other pressures, worry or fatigue. Boss (2006) emphasizes "our psychological absence in a therapeutic session is not acceptable; being fully present should always be our priority" (p. 197). If the therapist is suffering from similar distorted views as their client, the therapist cannot reasonably provide proper care (Lonergan et al, 2004). In a 1989 study by Guy et al. (as cited in Williams et al., 2010) found among psychologists who self-reported impairment, 36.7 percent admitted that client care was negatively impacted.

The National Association of Social Workers (2008) states clinical social workers have an ethical responsibility to address impairment to prevent harm to clients. Social workers' ethical responsibility as a professional, NASW (2008) ethical codes subdivision 4.05a, is to not allow their personal problems, psychosocial distress, legal problems, substance abuse or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility. According to NASW (2008) ethical codes subdivision 4.05b, social workers are to seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or take any other necessary steps to protect clients and others.

To ignore vicarious trauma could cause career and legal ramifications. The state law in Minnesota (2012), statute 148E.210, states the Board of Social Work has grounds to take action when a social worker (2) engages in conduct that has potential to harm a client, intern, student, supervisee or the public and (3) demonstrates a willful or careless disregard for the health, welfare, or safety of a client, intern, student or supervisee.

Furthermore, social workers are to address impaired social workers. The NASW (2008) code of ethics subdivision 2.09 under ethical responsibilities to the client, states social workers who have direct knowledge of a colleague's impairment due to personal problems, psychosocial distress, substance abuse or mental health difficulties that interferes with practice effectiveness should consult with that colleague when feasible. The role of the social worker in this instance is to assist the colleague in taking remedial action. If the social worker believes the impaired colleague has not taken adequate steps to address the impairment, then action should be taken through appropriate channels established by the employers, agencies, NASW, licensing and regulatory bodies and other professional organizations.

The ethical codes warn against practicing while impaired but does not specifically define how much impairment is “too much”. A study by Williams et al. (2010) looked at the impairment of psychologists in independent practice noted the importance of the distinction between impairment and distress. They conceptualized distress as resulting in individual disequilibrium in which one’s personal well-being is compromised. Distress can lead to impairment but only when the occupational functioning or standard of care delivered to the client is negatively affected. Every clinician experiences distress, but not all distress necessarily impacts practice negatively or causes impairment.

Individual Interventions for Vicarious Trauma and Secondary Trauma Stress

There is literature that advises clinicians how to manage stress, encouraging self-care, supervision, and personal therapy (Boss, 2006; Canfield, 2006; Hunter & Schofield, 2006; Lawson & Myers, 2010; Sexton, 1999). Individual strategies for managing STS include identification of therapist’s own reaction and themes of countertransference, developing an awareness of their own somatic signals of distress, understanding early warning signs of STS and VT in themselves, and accurately naming and articulating their trauma-related inner experiences and feelings (Boss, 2006; Canfield, 2006; Hunter & Schofield, 2006). It is suggested that therapists take inventory of their personal history with trauma and other unattended negative experiences because more life stressors can make one more vulnerable to secondary trauma. Attending to their spiritual life is important because VT can damage a clinician’s sense of meaning, connection, and hope. Regular supervision and practicing self-care are essential therapist prevention and intervention efforts for all levels of experience (Sexton, 1999).

Self-Care. Because mental health professionals are susceptible to VT and impairment that can affect their work, it is ethically imperative that they engage in self-care (Richards,

Campenni, & Burke, 2010). Richards et al. (2010) defined self-care as any activity that one does to feel good about oneself in areas of physical health, psychological health, spiritual health, and support. A study by Pickett (1999) surveyed 148 mental health professionals with specialties in social work, psychology, clinical psychology and others to examine the links between self-care practices, self-awareness, mindfulness, and well-being. Pickett (1999) along with Canfield (2003) found that mental health professional's frequency of participation in and views of the importance of self-care activities have been found to be significantly associated with their general well-being.

Coping Strategies. To alleviate STS reactions, therapist's attempt to manage the effect by affective distancing, seeking collegial and organizational support, supervision, exercise, self-care, and personal therapy for unresolved trauma history (Canfield, 2005). A balance of personal life and professional life results in clear thinking (Canfield, 2003). Secure attachments aide to protect a therapist from VT (Brandon, 2000). According to Boss (2006) self-reflection is to balance acceptance and mastery, make necessary changes and take responsibility. Mastery of this skill requires self-study, self-reflection, and self-development. Professionals must increase their own comfort with traumatic loss and find positive meaning. Boss (2006) recommends meeting regularly with trusted colleagues to listen without judgment to their stories of trauma and talk about the difficulty of trauma work. Boss (2006) further identifies the importance of the trauma therapists to tend to their own close relationships, family boundaries, roles, rules, and ritual celebrations including times of laughter and tears with peers and good friends, and find meaning in co-workers.

Personal Therapy. Personal therapy is an identified intervention for vicarious trauma. Bike, Norcross, & Schatz (2009), replicated a national survey conducted in 1987. This study

involved 727 psychotherapist, 234 of the participants were social workers. The survey inquired about their processes and outcomes of personal therapy experiences. Eighty-five percent of those that had sought therapy at least once were equally likely to seek personal treatment again, with an average of three times in their career. The top reasons for seeking therapy were couple distress (20%), depression (13%), need for self-understanding (12%), and anxiety and stress (10%) which was similar to the 1987 results. Ninety percent of the therapists reported positive outcomes from personal therapy with lasting effects on the therapist's reliability, skill, and empathy. According to Bike et al. (2009) a therapists training, identity, health, and self-renewal revolve around the personal therapy experience.

Health and Wellness. It is important for the trauma therapist to attend to self holistically to protect themselves from STS and VT. "Well counselors are more likely to help clients become well" (Lawson & Myers, 2010, p.163). Health is defined as the physical, emotional, and social well-being of individuals absent of medical and psychiatric symptoms, relational conflicts or social isolation (Boss, 2006). Wellness is defined by Myers & Sweeney (2010) as a way of life oriented toward optimal health and well-being, in which the body, mind, spirit are integrated by the individual to live life more fully within the human and natural community. Using this definition of wellness, Lawson and Myers (2010) surveyed 506 professional counselors from the American Counseling Association on counselors' performance which was defined as career sustaining behaviors, wellness, and their professional quality of life. The participants worked an average of 13.6 years, two thirds were licensed counselors, and 33 percent of their caseload contained traumatized clients. Fifteen percent of those clients were regularly at high risk for harm to self or others. Counselors with high wellness (creative, coping, social and physical activities) scores engaged in more career sustaining behavior (spending time with family,

maintain a sense of humor, balance professional and personal life, maintain self-awareness, reflect on positive experiences) and reported higher positive professional quality of life factors (compassion satisfaction versus burnout).

Supervisor Responsibility for Vicarious Trauma

Effective supervision plays an important role in a clinician's emotional development and can be the crucial component of prevention and healing from VT. According to Shulman (2010) it is the supervisor's responsibility to be the 'buffer' and help staff recognize and address STS. The clinical supervisor could use the therapist's countertransference to increase self-awareness, specific to working with traumatized clients (Beckman, 2002). For supervision to be effective, the supervisee must feel safe to express fears, concerns, and inadequacies. In 1995 Pearlman and Saakvitne (as cited by Sommer, 2008) recommended four components necessary for successful supervision of trauma counselors: a strong theoretical grounding in trauma therapy, attention to both the conscious and unconscious aspects of treatment, a mutually respectful interpersonal climate, along with education on VT.

The three major components of clinical social work supervision recognized today are administrative, educational, and supportive (Shulman, 2010). The most frequent need of a supervisee is support and emotional awareness (Ellis, 2006). Supportive supervision is concerned with increasing job performance by decreasing job stressors, increasing motivation, and enhancing the work environment (Coleman, 2003).

The supervisor shares the responsibility for services provided to the client. Shulman (2010) explains parallel process is when the staff is acting out their client's situation, probably unconsciously, in supervision and within their work environments. This gives the clinical supervisor an opportunity to examine any strong emotional reactions the clinician might

experience toward any particular client or issue (Beckerman, 2002). Supervisors of trauma therapists should be alert symptoms of STS and VT, including changes in counselors' behaviors and reactions to client's stories such as intrusive thoughts, feelings of being overwhelmed, signs of withdrawal and an inability to engage in self-care (Sommer, 2008).

Because no training program can provide specific education for every client situation a therapist may see, it falls upon the supervisor and agency to assure the trauma therapist is educated, aware, preventing, and intervening regarding the effects of VT. There are trainings for supervisors on how to assess for VT, educate supervisees on the negative effects of VT, and to provide support that promotes activities to manage the effects of working with trauma (Lonergan, O'Halloran, & Crane, 2004). Ellis (2006) conducted a study of nine counselors and nine supervisors regarding supervisory issues of critical incidents and training needs of the supervisor, which suggested the supervisor's training should include the supervisory relationship, competence, emotional awareness, and autonomy. The National Association of Social Workers' code of ethics (NASW, 2008) subdivision 3.01, under social workers ethical responsibility in the practice setting, states social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their area of knowledge and competence.

Supervisors of trauma therapists may also be at risk of VT. Dill (2007) consults organizations to prevent and intervene in situations involving supervisors who may be at risk of burnout and/or compassion fatigue and identifies education and training as protective factors. Dill's model of skillful supervision includes a supervisor that can self-identify when issues and stressors are rising, then takes the time to set limits, takes breaks, takes vacation, goes for a walk, etc. A skilled supervisor promotes self-care and role models healthy lifestyle for themselves and

their staff members and uses humor and laughter to combat stress. Skilled supervisors practice and encourage staff to distance themselves from case situations that are too stressful.

Despite the importance of supervision for trauma therapists' self-care and clients' protection, in 1995 Pearlman & Mac Ian (as cited by Sexton, 1999) found that only 53 percent of 188 self-identified trauma therapist received any form of trauma related supervision.

Agency Responsibility for Vicarious Trauma

It is imperative that the agency or employer pursue the underlying issues and systemic barriers that contribute to emotional distress and exhaustion of supervisors and staff. In 1999 Munroe (as cited by Sommer, 2008) claimed it is not sufficient for employers to instruct therapist's to take care of themselves off the job; active prevention measures should be a regular part of the work environment. In a study by Hopkins et al.(2010; as cited by ACS-NYU Children's Trauma Institute, 2012) child protection (CP) employees defined stress as emotional exhaustion, role overload, and role conflict which contributed to job withdrawal, work withdrawal, job search behavior, and exiting from the organization more than any other factor. Burbeck et al. (2002) conducted research in the United Kingdom, assessing the level of occupational stress in accident and emergency consultants. There were 350 participants. Those that worked full time averaged 57 hours a week. The respondents reported being highly satisfied with their jobs, yet 43 percent of the participants had scores over the threshold for distress and their levels of depression measured at 18 percent, slightly higher than other groups with 10 percent reporting suicidal ideation. The study concluded that the effect of long hours, stress on family life, and the lack of recognition was significant predictors of occupational stress.

Occupational stress in staff may affect morale and career longevity. When therapists are struggling with STS or VT, there may be consequences to their place of employment such as

staff turnover. Sexton (1999) reports loss of experienced and skilled staff can increase costs of hiring and training new staff. New staff may need more supervision and training than their predecessors. There is likely to be loss of energy, commitment, and optimism among staff negatively impacting the climate and culture of the agency.

Researchers have identified ways the organization can respond to STS and VT. Canfield (2003) advises that stress reactions, coping strategies, VT, and professional trauma history needs to be discussed openly with social services agencies to offer education and support that therapist's need. Shulman (2010) suggests the need look at the climate, structures, and agency policies in response to trauma. Several authors endorse agencies implement practices to diminish VT such as mandated scheduling of supervision, reducing caseloads, increasing vacation and sick leave, providing opportunities for counselors beyond trauma work and offer mental health care for counselors (Sommer, 2008). Other researchers offered the following organizational strategies to prevent and manage VT: prepare trauma therapist with training on VT, including identification and working through intense countertransference, create an environment accepting of work stress, acknowledging STS and VT as real problems and address it as an agency problem rather than attributing blame (Sexton, 1999). In addition, organizations may improve the environment by making resources available to help the therapist process their distress such as clinical supervision, consultation, case conferences, peer processing groups, personal therapy, trauma therapy training, professional development and regular team meetings (Sexton, 1999).

Recognition of STS stress and intervening before a therapist becomes impaired is the goal. To reach this goal, organizations must acknowledge the impact of trauma on direct workers, supervisors (both clinical and administrative) and directors. Five agency directors/clinical supervisors in a study by Culver et al. (2011) reported a need for additional

training for clinicians and support staff that work with trauma. One director in the Culver study said, "I feel like I am everyone's therapist and I don't think I do enough for myself" (p.39). Self-care, healthy boundaries, and balance in life were highlighted by all the directors in this study.

Dill (2007) encourages organizations to protect supervisors and staff from VT by screening for VT, offering employee assistance programs to meet with staff on a regular basis and provide trainings to warn, prevent, and intercept VT. Dill also suggests organizations develop peer supervision and endorse job rotation so staff can move out of high stress work and learn different skills.

Finally, prevention and intervention of VT includes looking at the organizational culture. Bell et al. (2003) offers a list of important inquiries of an agency regarding their response to VT. These reflective questions about agency culture can be found in Appendix D.

Profession Responsibility for Vicarious Trauma

The professional associations and training programs must take responsibility to train clinical social workers to prevent VT. Smith and Moss (2009) extended the ethical obligation to counselor educators to prepare therapists and supervisors to detect and resolve VT in themselves and their supervisees. It is important that educational institutions for graduate students inform future therapists about the signs of impairment and wellness behaviors (Bennett & Cooper, 2009). In a 1998 survey of training directors, Schwebel and Coster (as cited by Bennett & Cooper, 2009) reported minimal efforts to address self-care and psychological wellness in their entire graduate program. Eighty five percent of those surveyed reported educational material on self-care was not disseminated in their program, 63 percent reported self-care activities were not sponsored by their program, and 59 percent reported their programs did not encourage or promote self-care. This survey was conducted after graduate programs had received

recommendations to require personal psychotherapy and support groups for all students, integrate self-care into clinical supervision, ensure well-functioning and prevention of impairment into ethics courses.

National Response to Vicarious Trauma

As of late our nation has begun to recognize the necessity, value, and difficulty of working with trauma. The United States has chosen to lead a path of the prevention and intervention by educating others about the impact of trauma, specifically on children, and the need to provide trauma informed cultural practice (SAMHSA, 2012). Hartman, Gerrity, and Folcarelli (2008) proposed a memorandum of understanding about the impact of trauma across service delivery systems to generate an integration of goals, policies, and procedures that support trauma-informed services. In 2000, the United States Congress established the National Child Traumatic Stress Network (NCTSN) which is a collaboration of providers, researchers, and families to raise the standard of care while increasing access to services. The NCTSN (2012) offered a series of web-based trainings including 'Secondary Traumatic Stress Speaker Series' that defined STS, looked at organizational trauma stress, provider self-care, and offered trainings on assessments of STS and strategies for prevention and intervention.

Prevention and Early Intervention Efforts

Research identifies the phenomenon of STS and VT and offers recommendations for intervention of STS and VT, but there seems to be a lack of research about efforts to operationalize the prevention of STS and VT and evidence of effectiveness of the interventions. In 2009 Smith & Moss (as cited in Bennett & Cooper, 2009) suggested formal structures need to be put in place for prevention and interventions during times of distress. Boss (2006) identifies the goal of prevention is to decrease risk factors, strengthen protective factors, and build

supportive connections. Prevention includes balancing perception with facts, being tolerant of other views, reattributing blame when appropriate, taking responsibility when necessary, reframing events that cause guilt and shame, and rethinking power and control. Prevention also encourages optimism, reconstructs hope, offers supportive ways to find justice, helps regain pride, reduce stigma, builds community, and drives policy advocacy.

In 1995 Harris suggested (as cited in Canfield, 2003) a three stage prevention model for trauma workers. First stage is stabilization. Stabilization refers to stable activities and balance in life. The second stage is adjustment where the therapist defines what needs to be done to integrate the trauma information, and the third stage focuses on positively adapting to the trauma by using self-care.

Resiliency. Some suggest maintaining or increasing resiliency is the key to prevention (Gensheimer & Packer, 2012). Boss (2002) defines resilience as an individual ability to overcome or adjust to stressors and to maintain mental and physical health in the face of undue stress. Guilt, shame, and self-blame block resiliency (Boss, 2006). Ginsburg & Jablow (2006) defined resiliency as the trait that allows us to exist in a less than perfect world and move forward with confidence and optimism in the midst of adversity. In 2006, Meyer and Ponton (as cited in Lawson & Myers, 2010) wrote “resiliency in counselors is not an accident, rather it is the cumulative effect of counselors’ healthy decision making.”

Correspondingly, Ginsburg & Jablow (2006) developed the “7 C’s” model of resilience. The seven components are: *Competence*, described as the ability/skills to handle a situation effectively. *Confidence* is the solid belief in one's own abilities. *Connection* is the relationships with friends, family, school/work, community, and faith. *Character* is the fundamental sense of right and wrong to make wise choices. *Contribution* to the world gives a sense of purpose and

motivation. *Coping* is the best repertoire for protection of stress and is an array of positive, adaptive skills. *Control* is realizing the outcomes of their decisions and actions verses externalizing or given power to others.

Another resource for building resiliency and more recently developed is a handbook developed by the ACS-NYU Children's Trauma Institute (2011), titled "The Resilience Alliance: Promoting Resilience and Reducing Secondary Trauma Among Welfare Staff". This handbook was written to initially teach and help staff to apply emotional regulation and other resiliency related skills in a safe place with coworkers which would create mutual support and help improve the functioning of the workplace. The handbook focuses on three concepts of optimism, mastery, and collaboration.

Why Clinicians Choose Trauma Work?

Although this study does not explore the positive aspects of helping others with their trauma, it seems important to acknowledge there are benefits and motivation associated with trauma work. The term 'compassion satisfaction' is linked with providing therapy. It is the pleasure and satisfaction derived from working in the helping, caregiving systems. Compassion satisfaction may be related to providing direct care, to the system, to working with colleagues, beliefs about self or altruism (Bowman, 2012). A 1991 study by Mahoney and 1995 research by Schaubert and Frazier (as cited in Lonergan et al., 2004) identified the rewards of providing trauma therapy, including accelerated psychological development, a feeling of privileged participation in witnessing courage and resourcefulness, and satisfaction of being an agent of positive change. Hunter (2012) conducted a qualitative study with therapists examining the "therapeutic bond" between the client and therapist. Hunter found that the therapeutic bond gave therapists intense satisfaction and posed risks especially when working with traumatic client

experiences. However, the findings suggest that the experience of compassion satisfaction and the development of vicarious trauma resiliency counterbalanced the intense difficulty of bearing witness to the clients' traumatic experiences and the potential for vicarious traumatization.

In summary of the literature reviewed for this study, STS and VT are consequences of working with traumatized clients. VT is the pervasive images and reactions to the client's trauma that changes the therapist's view of the world and themselves. Trauma therapists need to be educated on STS and VT to increase awareness and recognize the symptoms. Trauma therapists need to seek supervision, talk with a colleague, or seek personal therapy to discuss their reactions to a client's trauma and also have access to a plethora of self-care and supportive resources.

Supervisors of trauma therapists need to be educated on STS and VT and transfer this learning to their staff. Supervisors need to develop skills to recognize the symptoms or assess for STS and VT in the trauma therapist. Supervisors can thus help preserve the quality services provided by the trauma therapist by responding with effective supportive interventions to prevent VT symptoms from becoming a disorder. Supervisors need to advocate for support from the organization for the trauma therapist in regards to VT and discourage a punitive response.

Organizations need to be informed of VT, acknowledge VT and its effects on the client, therapist, supervisor, as well as the potential negative effects on the entire agency. Organizations need to have policies and procedures that recognize VT and supportively direct the therapist and supervisor to respond to the symptoms of VT. Organizations need to diligently develop a climate and culture accepting and supportive of the therapist that may be affected by VT. The organization need to assure the clinician has regular supervision and permission to access other interventions such as peer groups and personal therapy. The organization need regularly train

staff about the signs and symptoms of STS and VT and endorse the team of co-workers help each other recognize and intercept STS and VT before impairment.

The graduate education programs and the professional counseling associations need to prepare clinicians, supervisors, and social service directors about VT to prevent harm to the therapist and the profession, and connect the links preventing harm to the client while the therapist is assisting the client work through their trauma.

In conclusion, vicarious trauma (VT) develops within the context of the client-therapist relationship and lies within the therapist working with trauma. If VT is not circumvented, it has the potential to have negative repercussions across all systems linked with the trauma therapist. Most often the responsibility to defend and intercept VT is solely placed on therapist. Yet, the literature review suggests the symptoms of VT at times may not be recognized by the therapist and the therapist may need the help of supervisors, colleagues, the employing agencies, and their professional associations.

The literature review identified recommendations, along with the ethical and moral obligations of the therapist, supervisor, organization, and profession in response to STS and VT. The gap in research is presented by the actual practice of sound early intervention efforts by the therapist, supervisors, and organizations. The questions remain are trauma therapists, their supervisors, and their organizations currently practicing to prevent VT? Are they aware of and recognizing the symptoms of VT? Are they prepared to intercept VT? Are assessments being conducted to identify the current VT prevention practices of the trauma clinician and are supportive resources readily accessible for intervention of VT? This researcher suggests that prevention and intervention of STS and VT is haphazard, lacking any formal prevention planning

by the clinical social worker and lacking formal intervention resources available for the clinical social workers.

Conceptual Framework

Ecological Perspective

The contextual view of this study takes an ecological systems perspective of the maladaptation to vicarious trauma in the micro, meso, exo, and macro systems. This study suggests that VT requires interventions and focused resolution work by each system to create healthy environments that work to prevent VT and offer culturally acceptable and accessible resources for VT.

Bronfenbrenner's is the founder of the ecological systems theory. The social ecological systems theory considers that individuals are sensitive to the environment and that each subsystem of the ecological system has the capacity to respond and transform, in this case to the impact of vicarious trauma (Keenen, 2010). From a social work perspective, the ecological framework allows for simultaneous focus on people, their environment, and their reciprocal relationships. It emphasizes the exchange between the systems changes and influences over time (Mizrahi & Davis, 2012). Bronfenbrenner (1995) identified key concepts of the ecological systems perspective which are ecological transition, reciprocal activity, and action research. Ecological transition occurs whenever the person's position in the ecological environment is altered as the result of a change in role, setting, or both. Moreover, transitions occur as a result of a change in the characteristics of the developing person. Reciprocal activity occurs when a person has developed a strong and enduring emotional attachment and when the balance of power gradually shifts in favor of the developing person. Action research is a social change

including adjustments in social policy and action that alter the existing ecological systems by challenging the social organization, beliefs, and lifestyle of a particular culture.

Micro level. The client-therapist relationship of trauma therapy occurs at the microsystem level of the ecological model. It is within this context of the microsystem that the trauma therapist is listening and working with the traumatized client to disclose their painful thoughts, feelings, and the details of a horrific trauma event. Within the micro level environment, the trauma therapist is susceptible to vicarious trauma. For this study, the microsystem environment includes the groups that most immediately and directly impact the trauma therapist in the element of therapy with the trauma client such as therapist's personal life stressors, work pressure and demands, and therapist's personal history of trauma. In 2006 Lazarus & Lazarus (as cited in Mizrahi & Davis, 2008) suggested stressors and coping strategies fit with the ecological perspective because it considers the characteristics of the person, the environment, and the exchanges between them. Stressors can have physiological or emotional consequences. Personal coping could be motivation, self-regulation of emotions, problem-solving, flexibility, hope, and an ability to seek environmental resources and to use them effectively (Mizrahi & Davis, 2008).

Meso Level. The mesosystem of the ecological systems theory refers to relations between the microsystems and the groups within the environment of the mesosystem. For this study, in the mesosystem the trauma therapist seeks clinical supervision to process their reaction to the client's trauma story to prevent or intercept VT symptoms. At this level, the trauma therapist reaches out for support from supervisors, peer groups, and/or other psychotherapists located within the work or community environment. The meso level is also where the trauma therapist may look to the larger community for interventions such as yoga classes, meditation, or

social events. Mizrahi and Davis (2008) found that informal supports of relatives, friends, neighbors, and spiritual groups may buffer stress.

Exo Level. The exo system of the ecological systems theory involves links between a social setting in which the individual does not have an active role yet the exo system affects the individual's immediate context. In this study the organization that employs the trauma therapist and the schools that train the therapists are located in the exosystem. As found in the literature review, VT could impact the climate and culture of an organization. If VT is ignored by the organization it could affect morale, retention, and mimic the painful struggles the traumatized client is experiencing. If the organization, including the agencies policies and procedures, recognize VT and demonstrate support for and prevention and intervention of VT, then the organizational culture and climate may be considered more healthy and ensure delivery of quality services.

Macro Level. The macrosystem describes the culture in which individuals live. In this study, the trauma therapist, their supervisor, and their organizations are all part of a subculture of professionals in therapy practice and trauma work. Trauma therapists are often members of professional associations, trained by educational institutions that are governed by a credentialing board of education, and licensed by state social work boards that establish the legal and ethical standards of practice. As a result, licensed professional therapists share common identity and values. Perhaps adding language to policies and procedures regarding STS and VT at the macro level would preserve the health and quality skills of the clinical social worker working with trauma and reduce the impact of vicarious trauma.

The policies and practices of the macro level organizations can be influenced by a larger cultural impact of trauma and vice versa. The larger culture of society can be affected by trauma

events as evidenced by the economic and social changes attributed to 9/11. Green and McDermott (2010) applied the ecological system to consider the evolution of neuroscience to understand the body, the person, and their environments with respect to the effects of trauma, suggesting focus should be on the ‘climates’ or culture that can sustain conditions essential to preserving human life and well-being.

In application of the systems perspective, Woodall (1998) said it well in his dissertation exploring the impact of stress, critical stress debriefing, PTSD, and secondary trauma victimization on professional and personal lives of emergency personnel. Woodall wrote “the best preventative is a well-managed incident conducted by a well-managed agency that requires well-trained, well-conditioned, well-supervised, and well-grounded personnel working together to achieve a set of defined outcomes through well-prepared and well-rehearsed operations and procedures” (p.iii).

In summary, the conceptual framework for this study integrates the information revealed in the literature review on VT and STS and applies it across the ecological systems; to the individual therapist, supervisor, organization, and governing boards. The gap is represented by the dearth of information of how these strategies to address VT and ST are operationalized in current practice by clinicians and the systems in which they work. The literature suggests there is a need for each level of the ecological system to be trained to recognize STS and VT, create a supportive culture in response to STS and VT, and offer accessible interventions for both.

Research Method

Qualitative Heuristic Research Methodology

This study utilized a qualitative heuristic approach to investigate the ‘everyday’ practice of prevention and interventions of STS and VT by clinical social workers working with trauma. Qualitative heuristic research methodology is applicable to all topics within psychology and social sciences. Heuristic research has an everyday orientation aiming to discover a real human event versus something mystical (Kleining & Witt, 2001).

Heuristic research is based on four principles that will be applied in this study: 1) the researcher should be open to new concepts and willing to change preconceptions of the data, 2) the topic of research may change after being successfully explored, 3) data collection maximizes variation and avoids one-sidedness, and 4) the analysis looks for commonalities and tries to overcome differences (Kleining & Witt, 2001).

Sampling

Participants for this study were selected by a snowball technique (Bodgan & Biklen, 1992). The selection process started with five licensed clinical social work supervisors found on the Minnesota Society for Clinical Social Workers website (2012) whose biographies included working with trauma. After the initial list of participants was called, names of potential participants were sought from key informants. Upon initial contact via telephone, email or directly with a potential participant, they were asked to provide names of three other trauma clinicians’ for potential participation in this study. This secondary ‘snowballing’ effort did not produce any participants.

Invitation and screening. Initial contact with the potential participating clinical social worker’s was by telephone or email. During the initial telephone contact this researcher provided an explanation of the study, determined if the potential participant met the screening criteria as shown in Appendix C, part 1, and asked for their voluntary participation along with

names of three other trauma clinicians that might consider participating in this study. Also shown in Appendix C, part 1, the inclusion screening criteria to participate in this study was a graduate degree in the field of clinical counseling, professional licensure as a clinical social worker, and a minimum of one experience working with traumatized clients. Following the initial contact, an email, as shown in Appendix A, was sent to the voluntary participant giving further information about the study including the informed consent to participate with confirmation of the date, time, and location for the research interview.

Informed consent. All participation in this research study was voluntary. The informed consent form, as shown in Appendix B, explains participation is voluntary, that there was minimal risk and no benefits to participating in this study, and provided contact information if the participant had questions or concerns. The participant was given the option to discontinue their participation at any time, stop the interview at any point, to not answer an interview question(s) or elaborate on answers to any of the questions. There were no benefits to participate in this research study. The participants were informed that this study had been approved by the institutional review board (IRB) at St. Thomas University, St. Paul, MN, and given the contact person for the IRB.

Protection of human subjects. The consent letter explained that tapes and transcripts of the interviews would be kept confidential and secure in a locked file cabinet at my home until the conclusion of the research project, then both would be destroyed. The respondent's identity and place of employment were kept confidential.

Participants were informed of the potential minimal risk for recall or recognition of vicarious trauma symptoms in themselves during the interview or after. For support in response to recall or recognition of symptoms of STS or VT, the participants were encouraged to seek

consultation with a supervisor or clinical colleague, access their Employee Assistance Program if available, or search NetworkTherapy.com to find a licensed professional. The participants were also given a handout titled “Indirect Trauma” (2000) by the International Society of Trauma Stress which includes information on vicarious trauma interventions.

Data Collection

Heuristic research utilizes a variety of data collection. With heuristic research methodology, the researcher collects as many types of data as possible using a variety of techniques such as observation, questioning, and review of relevant documents. Data includes a variety of respondents, viewpoints, practice methodology, data, time, situations, etc. Heuristic research collects data with consideration to the why, what, how, when, where of the everyday human event.

A variety of data specific to the clinical participants was collected for this study including demographics, practice sites, positions of employment while working with trauma clients, the various client populations served, the various types of trauma work, the varying levels of education on VT, the variety of therapist’s past and present experiences, and any recommendations for prevention and interventions of VT. The data sources utilized included interviews with the participant, observations by this researcher (which were documented in field notes), and their employer’s policies and procedures regarding employees experiencing vicarious trauma.

Heuristic qualitative interview. Qualitative heuristic research procedures are dialectical necessitating the practice of open-ended questions (Kleining & Witt, 2001). This researcher met individually, in person with each research participant. One participant was unable to meet face to face for the interview due to location and time constraints; therefore, the interview was

conducted by telephone. The semi structured interviews of the participants were audio tape recorded and guided by key questions derived from empirical research on vicarious trauma within the conceptual framework of the ecological model.

Interview questions. This researcher began the interview by asking demographic questions of each voluntary participant about their age, gender, ethnicity, education level, professional licensure, number of years of clinical work with trauma, size of case load and the number of trauma clients, total hours worked per week and total traumatized client contact hours per week, as well as the hours of clinical supervision.

The qualitative interview questions for this study as shown in Appendix C part 2, were developed through review of professional literature and in consultation with professionals working with trauma. The interview questions followed a micro to macro ecological systems structure, asking how clinicians practice self-awareness with respect to working with traumatized clients? Has the clinician received education on vicarious trauma or secondary trauma stress? Has the clinician recognized symptoms of VT in others; can they describe VT? Next the questions moved across the meso level regarding the impact of vicarious trauma asking how clinical social workers and their supervisors respond to symptoms of VT? What interventions are effective and which are ineffective for the clinician? What resources are readily available to circumvent STS and VT? What are the barriers to accessing such resources? Are trauma therapists getting support from their agency, if so, how? Are there agency policies at their employment setting specifically designed to prevent or intercept VT? During the interview, the participating LICSW's were asked questions that sought their personal recommendations, such as "What would the trauma clinician need to prevent VT and what would it take for the trauma therapist to preserve their health while working with traumatized clients?" The interview

concluded with exo and macro level questions asking the LICSW's for professional recommendations for clinical training programs, professional associations, and licensing boards to address vicarious trauma.

Data Analysis Processes

Heuristic inquiry. The rigor of heuristic inquiry comes from systemic observations of and dialogues with self and others. Heuristic inquiry emphasizes connectedness and relationship, focuses on a meaning and knowing through personal experience (Patton, 2002). According to Patton (2002), heuristic inquiry has five basic phases to the analysis process: immersion, incubation, illumination, explication, and creative synthesis. Immersion or intensity sampling relies on the full presence of the researcher to appreciate, smell, touch, feel the research experience including observing tone, mood, range, and content of the experience. Incubation is when the researcher withdraws allowing time for awareness and meaning of the research experience and information to development. The illumination phase is a deepening of meaning, brings new knowledge with clarity of critical patterns and themes. The next phase of the heuristic inquiry analysis process is explication which further explores the patterns to discover relationships. The last phase of this analysis is creative synthesis showing together the patterns and relationships; a new vision (Patton, 2002).

The interviews of this research project were transcribed and the data analysis followed the heuristic research methodology processes. Each transcribed interview was sent to the participating therapists for validity before analyzing the data. This researcher's field notes contained ecological systems mapping of each interview listing the micro, meso, and macro level data collected from each interviewee, an example is shown in Figure 2 along with personal

observations, thoughts, and feelings. The ecological mappings were analyzed in collaboration with themes of data from the interviews with the trauma therapists.

This researcher also audio recorded subjective preliminary findings based on the interviews which were later crossed referenced with the spread sheet of raw data categories and themes developed from the transcribed interviews. After examining the data for categories and themes, this researcher set the information aside to allow for different perspective upon reexamination.

Seek patterns of similarities. According to Kleining and Witt (2001) exploratory research such as heuristic methodology shows a picture of a topic moving away from subjective interpretation to a demonstration of patterns or themes that explains it. Heuristic research looks for commonalities across all the data collected. The first step in heuristic analysis is to determine if people interact in a way that allows for grouping answers and try to grasp what makes it similar. The next step is to find the common similarities in a different group of data. This may require reorganizing preliminary data. And the last step in analysis is to identify the overall pattern that integrates all of the details. Therefore, in application of heuristic exploratory research, the investigator is open to adjusting their thinking and evaluation of the human event (Kleining & Witt, 2001). Heuristic data analysis demonstrates validity and reliability by grouping similarities of the participants experience with vicarious trauma until saturation of similar data.

Overall, heuristic research provides an insight into a human event emphasizing openness and connectedness of the researcher to the research experience, followed by rigorous analysis of the commonalities that leads to discovery of a psychological or social meaning, essence, quality, and experience (Patton, 2002). This study used qualitative heuristic methodology, a semi

structured interview of the participant, observations, and detailed field notes, in attempt to describe the current status of prevention and intervention of vicarious trauma by clinicians, inductively moving from this researcher's interpretation of the results to recognizing patterns and relationships of the findings. Heuristic research allowed for a change in the topic and the possibility of a new explanation that could be applied generally to therapists working with trauma (Kleining & Witt, 2001).

RESULTS

This qualitative study investigated the current practices of prevention and intervention of secondary trauma stress (STS) and vicarious trauma (VT) amongst clinical social workers working with trauma. There were two aims of this research. The first aim was to determine if clinical social workers working with trauma are aware of STS and VT and practicing prevention techniques or early intervention. The other aim of this research was to identify the effective means to protect and maintain the passion, skills, health, and longevity of clinician social workers working with traumatized clients. Other underlying questions of this study included were whether trauma therapists are informed, prepared, trained, or made aware of STS and VT prior to engaging in such work and whether trauma therapists are left to their own devices with respect to STS and VT; whether there is prevention guidance, specifically from supervisors or organizations, to address STS and VT; knowledge of the resources or interventions a trauma therapist could readily access if they recognized symptoms of STS and VT; and whether they may access these resources while shielded from any stigma or concerns regarding their employment or professional licensure?

Heuristic begins with researchers experience with the topic. Because heuristic research methodology originates in the researchers experience with the topic, it is important to

understand this researcher's initial interest in secondary trauma. This research project and choice of research methodology evolved from a professional experience as a manager of therapists working with sexually abused children, families experiencing domestic violence, and clients that have died by suicide and terminal illness. This researcher values the therapists and support staff and desires to preserve their health and skills which subsequently assures the best quality therapeutic service to clients. Although the staff receive clinical supervision, this researcher was not sure that STS and VT was being recognized and addressed nor if there were accessible interventions and community resources for the therapist that may be in distress. This researcher wondered what other counseling agencies and clinicians did, if anything for self-care, personal therapy or consultation groups. Where are the supportive resources and are those resources effective?

Prior to this research, agency practice to address STS and VT was minimal; addressing STS and VT indirectly, but not overtly naming it. For example, one of the therapist's client attempted suicide by overdosing on medications then running away from their residence during a harsh winter night. Earlier that day the therapist had assessed the client for suicide risk after the client learned her husband wanted a divorce. The client denied any thoughts of suicide, actions, or plans and contracted for safety with the therapist. The therapist was later called when the client was discovered missing, and the police and family were looking for her. The therapist accessed supervision several times face-to-face and by telephone. She reported feeling shocked to hear the news of the client's suicide attempt, expressed incredible concern for the client's safety, felt anxious about the unknown, felt betrayal because the client had denied suicidal thoughts, and began questioning her clinical skills. The supervisors readily provided support to the therapist as often as needed. The supervisors and the therapist solicited the support of co-

workers and alerted the staff of the crisis. Upon locating the client and learning she was safe and receiving treatment at the hospital, the therapist again accessed clinical supervision to share feelings of relief about the client's immediate safety. In the following days, the supervisors processed the situations many times with the therapist expressing waves of relief, anger at the client, and motivation to improve suicide risk assessment skills. The case was presented to the staff consultation team to provide the therapist support and address recovery of the therapist, the client, and of their therapeutic relationship. The supervisors and consultation team also formally evaluated the situation as a sentinel event and discussed areas for improvement for the entire agency staff working with traumatized clients. STS nor VT was never overtly named by the therapist or the clinical supervisor before, during, or after this process. The supervisors did complete follow ups with the therapist regarding emotional wellbeing and assessing the level of confidence in their professional skills, accompanied by praise and support. There was no established formal procedural response to STS or VT within the agency that guided this process.

When this researcher learned about secondary trauma in a graduate class on supervision, the question arose as to where clinical supervisors seek support after providing supervision to supervisees who are sharing about their work with traumatized clients? This researcher polled random clinicians, first responders including police, emergency room workers, fire fighters, and chaplains regarding their familiarity with the concept of secondary trauma. Their responses yielded little to no awareness of STS, although they could describe a professional experience of working with 'victimized' clients.

This researcher's motivation for this project is to learn how to build resiliency in the therapist to safe guard them from the impact of working with traumatized clients. This mission was validated by a study by Hartman et al. (2008) concluding that all persons affected by trauma

deserve access to the best possible care provided by a trained, compassionate, emotionally healthy, supportive and supported therapist.

Participant Characteristics

Eight professionally licensed clinical social workers that work with traumatized clients were interviewed for this research project. Information about the participants is shown collectively in Table 1. Seven females and one male therapist participated in this study, all were Caucasian and ranged in age from 26 to 65 years of age for an average age of 52 years. Three participants have more than 20 plus years of experience working with trauma, with the least amount of experience being four years. The participants collectively averaged 21.38 years of working with traumatized clients. One therapist worked only with traumatized children, two worked primarily with adults, and five worked with children, adults, and their families. The therapists work with various populations of traumatized clients including those diagnosed with PTSD and other mental illnesses, and homelessness. Other clients have had physical injuries due to trauma, or experienced complex trauma, and still others were involved with correctional services. On average, 79.5 percent of their current case loads are traumatized clients. Four of the eight therapists provide clinical supervision to other therapists. Six of the therapists currently work full time and two work part time. Seven of the eight therapists routinely participate in individual supervision or consultation groups one to two times per month for one to three hours. The therapists currently work in a variety of settings including private practice, inpatient hospitals, corrections, and with families at their homes (family based services). Their experience covers the spectrum of for profit and not for profit work, as well as both local and national work. Participants have worked in agencies for a collective average of 15 years and five have worked in private practice for a collective average of seven years.

Heuristic immersion. There was a sufficient period of time between the literature for this study and the time of the participant interviews which allowed this researcher to be curious and open to learning and discovery rather than immediately comparing what the participants said to what was in the literature.

When interviewing the participants, this researcher first observed the difference in work environments. There were contrasts in settings from quaint outpatient counseling offices of those in private practice to the quiet commotion of the inpatient hospital setting. In hospitals, the presence of a diverse team of professionals and the presence of patients and families was observed. This contrasted with the correctional institution where the cell doors opened and closed as this researcher arrived and departed with the overwhelming sense of surveillance and feeling a generalized fear of the inmates.

This researcher was initially in awe of the therapists realizing their years of experience working with traumatized clients. All of the therapists were able to recall several clients trauma stories. The trauma therapists shared client trauma stories based upon recalled severity of the trauma, or their most recent trauma work, or the duration or frequency of the traumatized client-therapist relationship. One therapist said, “The more you see someone, the more you can recall their stories.” This demonstrates that therapists hold several memories of trauma of clients. Another therapist said, “I probably remember them (the trauma story) because you remember pain the best”. This demonstrates the impact on the therapist of listening to the client trauma stories.

When the therapists recalled stories of a client’s trauma experience, it felt “real” to this researcher. It was at those moments in the interview that this researcher realized the vulnerability of the therapist when listening to a client’s trauma story and the optimal moment

for the potential impact of secondary trauma stress and vicarious trauma to occur. It was clear that each therapist's practice was to be 'present' with their client as they recalled stories of their client's trauma, therefore making them vulnerable to STS and VT. The therapists shared these recalls of trauma stories:

"Yeah, one of the sessions was with this young man who reenacted the abuse right in front of me. He said my mother's bed was here, the table here; ashes were all over from her smoking. He was a little boy, age six, and he was standing in the back of the door, the door was cracked open and he could see through the crack of the door his mother and father fighting. His father was beating his mother because she would not give him a crack pipe, and he was watching; witnessing all of that."

"I have had patients who attempted suicide by violent means like shooting themselves or stabbing themselves or physically harming themselves. I can recall a patient who shot themselves, who was very intoxicated and had severe facial trauma, like broke all the bones in his face and required extensive facial reconstructive and is still undergoing a lot of those. He needed a tracheostomy, the whole nine yards. So the psychological work with him and these patients is challenging."

"The worst I ever heard was a client whose father and stepmother took her every weekend where she was totally trapped and they sexually abused her with a lot of very kinky weird stuff."

This researcher discovered during the immersion phase of this heuristic research that clinical social workers may name the stress, reaction, or impact of working with traumatized clients something other than STS. Eighty percent of the trauma therapists in this study used a different word for STS or VT such as compassion fatigue, burnout, or traumatized vicariously. Although the trauma therapist may have different names for STS as shown in Table 2, their definition and self-awareness of STS is similar as shown in Table 3. All the trauma therapists described personal experiences and self-awareness of STS and VT. A profound discovery of this study is that the stress or reaction felt by the trauma therapist during and after listening to the client's trauma story is an uncontrollable, natural, physical, emotional, and psychological.

Therefore, this study suggests that STS is normal and to be expected if working with traumatized clients.

The trauma clinicians in this study did not always differentiate between awareness and recognition of STS, although did distinctly identify the importance of awareness of STS and VT. The trauma therapists suggested that practicing self-awareness of STS in the presence of the client and after working with a traumatized client can help to manage the stress and impact of the trauma story on the clinician and the therapeutic process. All the very experienced clinical social workers that participated in this study reported practicing grounding techniques while with the traumatized client. Many used meditation, mindfulness DBT skills, energy fields, visualization and other grounding techniques before, during and after working with traumatized clients.

It's important to highlight all the clinicians interviewed reported they learned about STS and VT by personal experience. A few had recollections that VT was "slightly" mentioned at college and recognized that VT has been getting more attention as of late, but still often an add-on in workshops. One therapist stated:

"When I first started out in practice, trauma was not a buzz word like it is now, it was not that kind of identification. We were just learning about the effects of Vietnam War on veterans, so we have come a long way. I have worked with trauma survivors my whole career".

This study, although a small sampling, demonstrated the phenomenon of vicarious trauma is real. VT happens and it is different by symptomology, yet just as real as STS. The trauma therapists explained the difference between feeling stressed and experiencing "visceral reactions" when listening to a client's trauma story which is STS and vicarious trauma which is when the therapist feels traumatized by client's story and experiences symptoms of trauma such as "nightmares", "depression", "survivor's guilt" and "needing distance from trauma work for

own health and to get grounded into own world again.” The symptoms of VT seem similar to PTSD symptoms according to the DSM –IV-TR (2000), only the therapist is one step removed from the actual trauma event. Two of the therapists offered their personal account with vicarious trauma which brought an understanding to this researcher of the distinct difference between a therapist feeling distressed by listening to clients talk about their trauma and a therapist experiencing symptoms of being traumatized after listening to a client’s trauma story. The following are therapists’ description of vicarious trauma:

“I have my own memories of nightmares that were clearly connected to the exposure I had, they were horrifying and very traumatizing, and they would last for days. I was working in a place that I could talk about that and not be judged for it, and yes this does happen and that its part of the work. It’s the insidious part of it where you can be slow to recognize the process. I think it is not uncommon by any means. I began to feel so unsafe, feeling the evilness of humanity, and living out of that. I had to recognize that my life had really gotten off balance, that I didn’t have things, like self-care well in place, and I was working too much so I stopped any exposure to violence at all, I just cut it out. And to this day, I will not watch anything violent. I will completely not go there. Because there was so much, what felt like the evil dark side of life, that was being brought into the therapy context in which the clients had survived, that for me to really recognize all the good in the people, of my family, my friends, my colleagues, and people I know as positive is the counterbalance to that force. There is so much good, but it was a real process to be able to go back to that because that darkness is very powerful.”

“There were a few years I was burnt out. I was barely operating; it was work to get out of bed. I thought I was depressed, but it was compassion fatigue. This is when I was doing foster care with traumatized kids and lived with their stuff, day in and day out.”

The immersion experience of interviewing these clinical social workers led this researcher to valuable findings, feelings of admiration for each of them, and the realization of the incredible physical and emotional toll on the therapists when listening to the painful, disturbing trauma experiences of their clients.

Heuristic incubation. Incubation is when the researcher withdraws allowing time for awareness and meaning of the research experience and information to development. Following

each interview, this researcher felt an increase in energy and hyper stimulated by the information collected and the experience of the interview. This researcher purposely let the information and experience of each interview settle, journaled about the experience, then set it aside for a period of days before transcribing the interviews.

This researcher's field note entries during this incubation period were about the commonalities of the information shared by the participants and the 'light bulb' discoveries. In review of those notes, it was observed after a few interviews that each clinician presented a different theoretical foundation and thus created more questions around how these differences may have an impact on their personal experiences with STS and VT. Some examples; one of the therapists has a strong psychoanalytical theoretical perspective which she explained allowed for keen self-awareness of transference and countertransference issues when dealing with traumatized clients. Another therapist used cognitive behavioral therapy (CBT) more often combined with a sociology perspective. Two of the therapists incorporated strong practices of dialectic behavioral therapy (DBT) and mindfulness skills when working with clients, and yet another therapist reported frequent use of brief therapy, motivational therapy, and solution focused therapy because of their practice model with traumatized clients and their families.

It was during this incubation reflective time that this researcher discovered the trauma therapists of this study, each working in different environments and locations from each other, had similar descriptions of their work with traumatized clients as shown in Table 4, and a similar definition of trauma as shown in Table 5.

Heuristic illumination of the findings. The illumination phase of the heuristic research model is a deepening of meaning, bringing new knowledge with clarity of critical patterns and themes. This researcher initially felt overwhelmed by the vast amount of insightful raw data and

the personal learning. Significant time was spent entering the raw data from each interview question onto a spread sheet, and analyzing the categories for themes to deduce the big picture information or discoveries and implications, as well as interpreting the information into an ecological perspective. This researcher discussed the preliminary findings with the research committee members, a research consultation team, and a fellow who examined the categories and themes for reliability.

Systems Perspective of the Findings

The following superordinate findings of this research are based on a small sample of eight trauma therapists' description of the current prevention and intervention efforts of vicarious trauma by clinicians from an ecological perspective. A visual explanation of the ecological framework and systems considered of this study on STS and VT is shown in Figure 2.

Micro level findings. It is within this context of the microsystem that the trauma therapist is listening and working with the traumatized client to disclose their painful thoughts, feelings, and details of a horrific trauma event. Several of the findings from the therapist's perspective of their work with trauma and their experiences with STS and VT were mentioned in the prior section. Another important finding that evolved from the micro level during the heuristic research illumination phase is that STS is not preventable, but VT may be intercepted. Although all the trauma clinicians that participated in this study explained STS and VT as normal reactions when working with traumatized clients, VT seemed to require a more pronounced treatment regime that included a definite space and time separation from the trauma work to regain a balanced, realistic world view. The participating trauma therapists indicated VT could possibly be prevented and STS could be managed by consistently practicing healthy living,

applying self-care strategies, accessing and utilizing clinical supervision to proactively manage experiences of STS and symptoms of VT, and balancing work and life outside of work.

A superordinate finding of this study is that individualized self-care plan is a trauma therapist's armor for intervention of STS and prevention of VT. Micro level resources and self-care regimes the research participants are currently using to manage STS and prevention of VT is shown in Table 6. Trauma therapist's self-care routines include leaving work at the agency door, enjoying activities unrelated to work, physical activity to release the stress toxins, cognitively positively reframing their thoughts about the trauma, and applying grounding techniques in the moment. To address STS and VT at the micro level, these LICSW trauma clinicians recommended "talk about STS", "do self-care", "seeking supervision", practice "grounding" skills, and "write self-care plans as a preventative measure rather than waiting for something to happen".

Meso level findings. In this study the meso level is where the trauma therapist may look to their work environment and larger community for interventions of STS and VT. This study found that initially trauma therapists recognize VT and STS as a normal part of working with traumatized clients and then they look for support from community resources. The trauma therapists in this study identified a need for supervision or consultation and warn "do not do trauma work in isolation." This researcher found that those in private practice have to search for or develop a support network to address secondary trauma stress. All of the trauma therapists in this study identified a helpful resource to address STS and VT is to frequently discuss STS with a trusted colleague. One trauma therapist said, "You must find a consultation group that matches your style and meets your need."

A valuable discovery with implication for clinical supervisors is that trauma therapists identified the most effective meso level resource for the trauma therapist is a clinical supervisor that has experience working in trauma and directly asks the trauma therapist about STS and VT. The trauma therapists offered the following descriptions of an effective clinical supervisor:

“They “ask”, “validate”, “affirm”, and normalize VT.”

"The supervisor asks in a supportive not aggressive way 'what part of the case situation is really more about me or if I got triggered by something?'"

“Individual consultation is most effective because I can spend more time on it (STS and VT), get more support, and I trust this person”

Another significant discovery is these trauma therapists identified fear as the only barrier to accessing resources. The trauma therapists described their barriers to accessing resources to address STS and VT as “internal”, “myself”, “denial” and highlighted that the fear is “not knowing it’s [STS and VT] normal... but give yourself permission to address it”.

Exo level findings. In this study the organization that employs the trauma therapist and the clinical training institutions are located in the exosystem. This study found that businesses that recognize trauma as a primary issue of their client population responded by creating a culture that acknowledges and addresses STS and VT. For example, the trauma clinicians that worked at trauma hospitals reported a supportive climate where as trauma is not the primary focus for correctional institutions. The trauma therapists in this study indicated they need a ‘sense of community’ or culture that recognizes and supports their working with traumatized clients. The trauma therapist described this culture as one that normalized STS and VT by providing a nonjudgmental, acceptance, and an expectation that STS and VT will happen when working with trauma. One of the therapists was emphatic about the necessity for building a

‘culture’ stating, “If I didn’t have agency support I could not see trauma victims.” Another trauma therapist said, “The culture of my work acknowledged VT; they were sensitive and adapted to the workers.”

The trauma therapists further described an agency that recognized STS and VT would provide or endorse benefits such as “supervision, training, paid vacation and flexible scheduling”. Another therapist highlighted the importance of agency recognition of STS and VT on retention of therapists and continued high quality therapy:

"I quit several jobs because of the amount of self-care I had to do to be able to work with traumatized clients. There was not enough time in day (to meet session quota’s) and get all my self-care, just to be able to do the same amount of trauma work the next day".

The trauma therapists that participated in this study offered their professional recommendations to address STS and VT at the meso and exo system levels as shown in Table 7. They recommended train the supervisors, administration, and agencies about STS and VT, develop trusting relationships between trauma therapists and supervisors and administration, build skills in the clinical supervisor of trauma therapists, and build an agency ‘culture’ that recognizes, normalizes, and expects STS and VT.

Macro level findings. The macrosystem describes the culture in which individuals live. The macro systems considered for this study develop the policies, procedures, and laws of the governing boards that influence clinical practice with clients and trauma, such as the national and state associations of social workers, state licensing boards, and education accreditation councils. None of the trauma therapists, in their entire trauma work history, could recall or produce a policy, procedure, or laws that specifically address STS and VT. Although VT has been getting more attention as of late, the trauma therapists reported that macro level institutions could help manage the impact of STS and VT on the care systems working with traumatized clients. This

could be accomplished by putting more emphasis on training the trauma therapist, clinical supervisors, the trauma agencies and administration to be aware. All levels of the system may benefit by recognizing and preparing for STS and VT. Recognition of STS and VT may lead to a professional culture that, as one of the participating therapist said, has a “this (STS and VT) is normal attitude”. The LICSW trauma clinicians that participated in this study offered the following macro level recommendations to address STS and VT: Normalize STS and VT, provide training specific to normalizing and expecting STS and VT to occur when working with trauma, and broaden the scope of thinking about trauma to include promoting the prevention of abuse. This information and more participants’ comments for macro level interventions can be found in Table 8. A summary listing the micro, meso, exo, and macro level findings of this study is shown in Appendix F.

Heuristic creative synthesis. The last phase of this heuristic data analysis is a creative synthesis which pulls together the patterns and relationship of the findings to form a new vision. The investigator has to be open to adjusting their thinking and evaluation of the human event. Initially, this researcher was looking for resources for therapist experiencing systems of STS and VT but discovered much more. The critical findings of this research project are:

1. If working with traumatized client population then expect and normalize STS and VT.
2. STS will happen and VT could happen; plan for it, talk about it, and develop an ecological system of resources to equip the trauma therapist and their organizations.
3. We may consider that there are parallel experiences and similarities in the effective treatment of the therapists experiencing STS and VT when working with traumatized clients to that of the traumatized client. This would need additional research.

Discussion

This study offers insight into eight trauma therapists experience with STS and VT. “Qualitative studies cannot provide the seeming ‘objectivity’ of research but can provide an in-depth perspective from those that were there” (Lloyd and Dallos, 2008, p.20). Several of the results of this study matched the data found in the literature review. More specifically, the results of this study are similar to a 2006 study by Hunter and Schofield which considered how counselors from Australia cope with traumatized clients from the therapist, supervision, and organizational perspective. An additional strength of this study is the depth of experience of the research participants as clinicians working with trauma and the fact that all were licensed clinical social workers.

The trauma experienced licensed clinical social workers that participated in this study are aware and recognize secondary trauma stress when working with traumatized clients, but none had been fully informed, prepared, trained, understand or aware of vicarious traumatization prior to engaging in the work. Unfortunately, these clinicians learned about STS and VT through personal experience. None of the trauma clinicians in this study could describe any prevention of VT nor ever participated in a structured resiliency building programs for trauma therapists that the literature suggested (Boss, 2006; NCTSN, 2011). None of the clinicians had created a prevention plan or self-care plan prior to working with trauma clients.

Their lack of prevention efforts may be understandable because according to the experienced trauma clinicians in this study and the literature review, STS is not preventable. The trauma clinicians in this study experienced STS when “present” with the client as the client reenacts or narrates their trauma; just as Perlman (1999) discovered. They describe STS as a normal, natural physical and psychological reaction when the trauma therapist carries the burden

of the client's pain with the client. This description of STS is similar to other research (Bennett & Baker, 1999; Canfield, 2003).

An estimated 25 percent of trauma therapists experience VT according to the literature reviewed (Canfield, 2005; Culver et al., 2009; Lonergan, O'Halloran, & Crane, 2004; Sommer, 2008), which matched the results of this study. The trauma clinicians described VT as perceiving the world through depression; cynical, pessimistic and lacking trust in others. It may be that VT is preventable but that requires further research.

Although STS may not be prevented, it can be managed. The clinicians that participated in this study emphatically stated that they could not work with trauma if they did not practice self-care or have supportive clinical supervision. Self-care strategies used by therapists in this study match several strategies of therapists found in the research reviewed (Lawson & Myers, 2010; Hunter & Schofield, 2006). These trauma clinicians reported numerous self-identified community resources they could access from training, to exercise classes, to attending sporting events and personal therapy. All of the participants developed a supportive trusting relationship with a clinical supervisor, colleague or team of consultants to call upon as needed.

Consistent with the themes in the literature, this study identified that if STS and VT are not circumvented, then STS and VT have the potential to instigate negative repercussions for the therapist and across all the systems linked to the trauma therapist (Bell et al., 2003; Boss, 2006; Hunter & Schofield 2006; SAMHSA, 2011). The literature reviewed and this study shows that the responsibility to address STS and VT is placed heaviest on the trauma therapist. This seems unfortunate because all the trauma therapists were easily able to identify a coworker that was struggling with STS or VT from working with traumatized clients more than they were able to recognize or admit to experiencing the same struggles. Also, the seasoned trauma therapists in

this study rely heavily on the clinical supervisor to make inquiry regarding the clinician's experience with STS or VT when working with traumatized clients. It seems reasonable to suggest that the licensing boards require all clinicians submit a self-care plan as the likelihood is great that a clinician would encounter traumatized clients and be exposed to STS and VT.

To provide quality services to traumatized clients day after day, the trauma therapist need to have a platoon of coworkers that are informed about STS and VT to recognize it in the trauma therapist and offer support and intervention resources. The clinical supervisors of the trauma therapist needs to be well educated on STS and VT to inform, recognize, and support the therapist as they work with traumatized clients. The clinical supervisor is also in a prime position to inform the meso and exo system leaders such as agencies administrators, directors, counseling educators, and professional associations about STS, VT, and the needs of the trauma therapist so they can continue to provide their best therapy during every session with a traumatized client. It seems reasonable to suggest that clinical supervisors are mandated to demonstrate training to effectively address STS and VT and preserve the wellbeing and profession of trauma clinicians. And it seems equally important that clinical supervisors are trained on how to develop a self-care plan so they can guide their supervisees on this task. The supervisors should create a self-care plan of their own due to likely subsequent exposure to trauma.

Currently, agencies, administration, educational institutions, professional associations, and licensing boards rest the responsibility for STS and VT on the trauma therapist. This is unfortunate as this study and research by Sexton (1999) indicated that agencies are experiencing turnover of high quality therapists because the agency, administration, nor culture of the profession recognizes STS or VT. Rather, agencies push more client contact hours and disregard

the therapist's need for time to practice self-care and/or take a needed break from working with traumatized clients. The trauma clinicians that worked at agencies that were not trauma informed and/or did not recognize abuse, neglect, and violent crimes as trauma, did not feel supported or understood and suggested these agencies needed training on STS and VT.

There is a lack of recognition of STS and VT, formal resources, and minimum standards to address STS or VT across the all trauma systems. None of the therapists in this study knew of a formal list of available resources nor ever had policies or procedures that specifically address STS or VT. This is an area for further exploration. The trauma profession needs to acknowledge STS and VT as normal and to develop a list of supportive resources for all trauma responders. The macro system leaders need to be well versed on STS and VT to develop laws, policies, procedures that create a climate and culture that normalizes, expects, prepares, and supports trauma workers. It is the ethical responsibility of the entire client care system to protect the client from harm by protecting the trauma therapist from STS and VT.

The most valuable result of this study is the clear message that STS and VT is normal. Each trauma therapist and the literature reviewed in this study determined STS was a normal response to working with traumatized clients, but collectively STS or VT had never been normalized for them prior to their own personal experience. The differences between this study and the literature reviewed is that the findings of this study emphasize that STS and VT are normal and an expected response if working with traumatized clients whereas the literature generalized it as a possible phenomenon, as if a plague or stigma.

The participating therapists of this study explained the need to have self-awareness for the experience of STS and learned to employ 'protection techniques' such as visualizing a wall or energy field around them so as not to absorb or react to the client's pain and suffering but

rather walk alongside as the client works out the pain of the trauma. There was little information in the literature review that addressed such ‘protection techniques’ in the presence of the client. This could be an area for future research.

This study found the only barrier to accessing resources to address STS and VT was the therapist themselves, more specifically the therapists fears. The literature reviewed did not address specific barriers to resources rather insinuated the employing agencies and administration were not trauma informed which accounted for the lack of resources. It’s important to note that all of the trauma therapists in this study lived in a metropolitan area where resources are generally plentiful. Also, all the therapists in this study had several years of experience which awarded them time to search for the resources, which they determined by trial and error what resources were effective.

One purpose for this research project, as a manager of therapists, was to identify and develop an effective ecological systems response to support a trauma therapist’s ‘everyday’ experience of STS or VT. This study has fulfilled that purpose and a rough outline for implementation of a systemic trauma therapist support program is shown in Appendix E.

This study could be easily replicated and the data could be strengthened by a broader diversified sampling from a larger geographical area. It may be helpful to compare qualitative data from trauma therapists that work in the metropolitan area with that of those that work in rural areas. It may be equally beneficial to compare qualitative data on an ecological perspective of STS and VT from trauma therapists across the states, regions or even broader between countries.

It may be helpful to compare self-care strategies, training preparation, resources, and interventions for STS and VT across similar psychotherapy disciplines such as psychologists,

marriage and family therapists, and professional counselors. For an even broader perspective on STS and VT, it could be beneficial to compare the qualitative data on training, intervention practices, and resources of trauma physicians, nurses, chaplains, military, police, fire fighters, and EMT's; all first responders.

A reasonable response to this research would be to investigate when and how undergraduate and graduates social workers are educated and prepared for STS and VT.

Limitations

The study was limited to a small sample of eight participants due to limited resources including both time and funding. The sample lacks in cultural diversity as all participants were Caucasian, seven of the eight were female and practiced in the metropolitan area. The data collected was primarily from the perspective of the trauma therapist, although coincidentally three of the therapists are also practicing clinical supervisors. One had a leadership position in a professional association, and several had their own private practice.

Conclusion

This study suggests the responsibility to address STS and VT should not be solely placed on the trauma clinician, but rather requires shared responsibility across all the ecological systems of trauma care. It is important to train all clinicians as well as the entire trauma care systems to recognize STS and VT to support and normalize it for those that are experiencing it. The missing element seems to be to expecting and preparing for STS and VT. To systemically normalize STS and VT may require awareness and commitment by the macro level system leaders to make STS and VT a priority. Finally, when STS and VT are recognized and supportive systemic interventions are applied the performance of the trauma worker may be preserved which leads to quality customer services.

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APPENDIX A

RESEARCH PARTICIPATION INVITATION

Dear Potential Research Participant;

I am a graduate student in clinical social work at the College of St. Catherine/ University of St. Thomas, St. Paul, MN. As part of my clinical social work program requirements, I have undertaken **a research project that investigates the current early intervention and prevention efforts for secondary trauma stress and vicarious trauma by clinical social workers working with trauma.** My research is supervised by my graduate research project chair, Dr. Felicia Sy, and this research project has been approved by the University of St. Thomas Institutional Review Board.

I am seeking participants with a graduate degree in the field of clinical counseling, professional licensure as an LICSW, and at least a year of experience working with traumatized clients. Participation in this study will involve a 60 minute in person interview with me and completion of some demographic questions. The total time involved in participating in this study is 90 minutes.

Your name and other identifying information will be kept confidential. Attached you will find the Informed Consent notification form for this research project that will explain in further detail the purpose of the research, the benefits and risk to participating in this project, along with contact information for supervisors of this research project.

If you would so kindly choose to voluntarily participate in this study, please respond to me by email at knberscheit@gmail.com or by telephone 763-360-0583.

If you are unable to participate in this research project, I would greatly appreciate if you would share the names and numbers (with permission) of other clinical social workers that work with trauma. I would appreciate at least three other names and contact information for other clinical social workers that work with trauma. Please email me their name, number and/or email address (with their permission) so I may contact them. Thank you for considering this request.

Sincerely,
Kelly A. Berscheit, BSW, LSW

Researcher:

Kelly A. Berscheit, BSW, LSW
Becker, MN
knberscheit@gmail.com
763-360-0583

Research Project Chair:

Dr. Felicia Sy
University of St. Catherine/St. Thomas University
Felicia.sy@stthomas.edu
(651-962-5803)

APPENDIX B

INFORMED CONSENT: PARTICIPATION IN RESEARCH UNIVERSITY OF ST. THOMAS

Purpose for the Research

This is a qualitative study of clinicians' current practice to prevent and intercept vicarious trauma.

The goal is to identify the current practices, needs, and recommendations of therapists to armor themselves from the impact of working with traumatized clients. There are several reasons for this research: a) to determine if the current precautionary efforts of the trauma therapist to deflect the impact of secondary trauma stress and vicarious trauma match the level of warnings and advice found in the vast amount of literature, b) to improve clinical practice, and c) articulate the needs of the therapist to improve supervision, training, organization and professional support. The aim of this research project is to learn factors to preserve the health of the most important tool in therapy; the clinician. This study is being conducted in partial fulfillment of the Clinical Social Work Master's degree at the University of St. Thomas/St. Catherine University.

Confidentiality

You were selected as a possible participant because you are a licensed clinician that has worked with trauma. Participation in this study is voluntary and confidential. All identifying information of the participant and their place of employment will be kept confidential. The audio tape, transcriptions of interviews, field notes, and gathered documents associated with this study will be destroyed after completion and presentation of this research project. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Kelly A. Berscheit, a graduate student in Clinical Social Work at the School of Social Work, St. Catherine University/University of St. Thomas with instructional assistance from Dr. Felicia Sy.

Procedure

If you agree to participate in this study, upon initial contact with you I will ask you preliminary and demographic questions, and ask you to partake in an interview which will take approximately one hour. I will be audio taping the interview, then transcribing the interview for data analysis. To assure validity of the information, I will present the findings back to you. Your transcript will be kept in a locked file cabinet at my residence. I will delete the recorded interviews after the research project is completed and presented to the public in May, 2013.

Benefits

There are no direct benefits for participation in this study. There is no monetary compensation for your participation in this research project.

Risks

There is minimal risk to participating in this research. During the interview, participants will be encouraged to explore the impact of vicarious trauma and their responses to vicarious trauma. The potential minimal risk in this study is that the participant may recall or begin to recognize symptoms of secondary trauma stress or vicarious trauma and this may be disturbing. The participant has permission to pass on a question or terminate the interview at any time if feeling uncomfortable. There are no repercussions for withdrawing from this study. Should the participant feel any disturbance during or after this interview the participant is encouraged to see the support of a supervisor or consult with a clinical colleague, access their Employee Assistance Program (EAP) if available or search Network Therapy.com to find a licensed professional. Also to address any minimal potential risk to the participant, this researcher will provide the participant with a handout titled “*Indirect Trauma*” (2000) by the International Society of Trauma Stress which includes information on vicarious trauma interventions.

Contact Information

If you have any questions, feel free to ask me. If you have any questions after the interview that are related to the study you may call (763-360-0583) or email (knberscheit@gmail.com) me or my research advisor, Dr. Felicia Sy (651-962-5803) or email (Felicia.sy@stthomas.edu). You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

Your signature on this form indicates:

- you have decided to voluntarily participate in this study, and
- you have read and understand the information given above or the information has been verbally explained to you.
- you understand that the purpose of this study is: to investigate the current early intervention and prevention efforts of secondary trauma stress and vicarious trauma.

Signature of Participant

Date

Print Name of Participant

APPENDIX C, PART 1

(Initial contact: *"Hello, I am a Clinical Social Work student at University of St. Thomas. I got your name from _____. I am conducting research on clinicians working with trauma. Do you have a couple minutes to talk with me? Or is there a better time to call you?"*)

DEMOGRAPHIC and SCREENING QUESTIONS:

Participant's name: _____

Participant's email address: _____

Professional credentials (degree and licensure): _____

Age: _____ Gender: _____ Race/Ethnicity/Culture: _____

Years of Experience with Traumatized Clients: _____

Current Percentage of Traumatized Clients on your Caseload _____%

Current Form (ex: individual) and Frequency of Supervision _____

How many years have you worked with trauma in an agency? _____

How many years have you worked with trauma in private practice? _____

(Concluding initial contact: *You have met the criteria to participate in this research project-then move to next questions, or I am sorry you did not meet the criteria for participating in this research project. I am relying upon contact for leads to participants; can you share the names of three other clinicians working with trauma. Thank you for your time*)

1. _____

2. _____

3. _____

If the professional meets the criteria to be an interview participant:

In the next month, what days and times work best for you to participate in this study? Or what days and times are you unavailable to participate in the interview? _____

Any suggestion where you would like to have your interview?

APPENDIX C, PART 2

(Upon meeting for interview: *Thank you for participating in this research project. I appreciate the time you giving me. We first need to review the consent to participate form. You are aware that your name and places of employment will be kept confidential. I would like to email your interview transcript to you for validity, can I get your email address?_____.* *Are you ready to start the interview questions?)*

INTERVIEW QUESTIONS

1. What is your definition of trauma?

Micro Level

2. Can you describe your work with trauma?
3. While maintaining confidentiality, are there any client trauma stories that you instantly recall?
4. Can you describe or explain how you practice self-awareness while working with a traumatized client?
5. Are you familiar with the concept of secondary trauma or vicarious trauma?
 - a. If yes, what is your definition of ST or VT?
 - b. If yes, how did you learn about ST or VT? (Training)
 - c. If no, can I share the definition of ST or VT with you? (Provide handout of definitions), then proceed to question....
6. What elements of ST or VT have you recognized in yourself or others?
7. How do you respond or would you respond to ST or VT? (Self-Care)

Meso Level

8. What resources are available to address VT? (Interventions)
 - a. How did you learn about the resources?
 - b. Are there resources readily accessible?
 - c. What resources are most effective?

- d. What resources are not helpful?
 - e. Are there barriers to accessing the resources?
9. As a trauma therapist, how are you getting support from your work place/agency?
10. How does your clinical supervisor address VT?
- a. Of the responses to VT by your clinical supervisor, what is most effective for you?
11. What are your work place/agency policies and procedure that address VT?
- a. Are the policies and procedures endorsed?
 - b. Are the policies and procedures helpful?

Needs and Recommendations

12. What would the trauma therapist need to effectively address ST or VT?
13. What would the supervisor of the trauma therapist need to effectively address ST or VT?
14. What would the agency need to effectively address ST or VT?

Macro Level

15. Any recommendations for clinical training programs or professional associations to address ST or VT?

APPENDIX D

Reflective Questions about Agency Culture Regarding Vicarious Trauma

Bell et al (2003)

1. Does the culture acknowledge the impact of trauma work on the individual and the organization?
2. Does the organization make staff self-care part of the mission understanding that it affects client care?
3. Is the workload of trauma cases distributed among staff?
4. Are staff encouraged to participate in social change activities, outreach and influencing policy which can create a sense of hope, empowerment and be energizing?
5. Is the organization proactive and collaborating on services for clients and resources or paying to alleviate stress in the therapist's work with traumatized clients?
6. Is the work environment safe, comfortable, and private for the therapist to work?
7. Does the agency have safety protocol for protection of the staff, is there a security system or security guards?
8. Does the work environment have inspired posters versus regulation?
9. Is there a break room where staff can address self-care needs, soft music, and comfortable furniture?
10. Does the agency offer a training budget for the therapist to gain education on VT?
11. Is there opportunity and encouragement for staff to informally debrief with peers or formal debriefing opportunities at the agency?
12. Are there peer support groups such as consultation, case conferences, and clinical seminars to provide help prevent vicarious trauma.
13. Does the agency provide and encourage supervision?
14. Does the administration require the supervisor is trained in supervision of trauma therapist?
15. Does the supervisor have the opportunity and resources for self-care?
16. Does the agency provide to the trauma therapist resources for personal therapy, structured stress management or structure physical activities such as walking, meditation, or yoga groups?

APPENDIX E

Systemic Trauma Therapist Support Program

(Berscheit, 2013)

Program Goal: Normalize STS and VT as an expected element of working with traumatized clients for the therapist, supervisor, and administration.

- I. Awareness: All staff including administration are aware of the concept of STS and VT via training and sharing of experience.
- II. Recognition: All staff can recognize secondary trauma stress and vicarious trauma not only in self but in each other, with compassion and without judgment.
 - a. Task: Ask each micro, meso, exo level employee/employer to identify what can be done to prepare and addresses STS and VT and supportively respond to working with traumatized clients.
- III. Require Therapists and Supervisors to develop a self-care plan that are shared with administration for support.
- IV. Require and fund clinical supervisors to get training to effectively address STS and VT.
- V. Ensure the clinical supervisor allows adequate supervision time for the trauma therapist and specifically asks about STS and VT during supervision.
- VI. Ask administration to collaborate with the trauma therapists to develop and endorse policies and procedures that address the supportive needs of the trauma clinician such as but not limited to flexible schedule, health care benefits, mandated vacation and breaks.
- VII. Ask administration to support trauma therapists and clinicians participation in community professional consultation teams specifically for trauma therapist that addresses STS and VT.
 - a. Task: Research and develop a list of community consultation options for the trauma therapist.

APPENDIX F

Ecological Systems Perspective of Secondary Trauma Stress and Vicarious Trauma From Trauma Clinicians

(Berscheit, 2013)

This is a summary of the micro, meso, exo, and macro level findings of a study on STS and VT. Eight trauma clinicians with an average of 23 years of experience working with traumatized clients participated in this qualitative study.

Micro Level Discoveries

1. STS and VT are real.
2. STS and VT are normal reactions to working with trauma.
3. STS and VT are to be expected if providing clinical social work with traumatized client.
4. STS is not preventable; rather it is a natural, uncontrollable response to working with trauma that may be managed.
5. 80 percent of the clinicians interviewed used a different word for STS or VT, but their definition or description of the concept was similar. Some of the therapists called it compassion fatigue, burnout, secondary trauma, traumatized vicariously.
6. STS is a feeling stressed and experiencing “visceral reactions” when listening to a client’s trauma story whereas the participants described VT occurs when the therapist is traumatized by client’s story and experiences symptoms like PTSD such as nightmares, depression, ‘survivors guilt’ and needing distance from trauma work for own health and to get grounded into own world again.
7. With respect to STS and VT, the best intervention for the trauma therapist is to live a balanced healthy life and talk about their experiences of STS and VT.

Meso and Exo Level Discoveries

8. Trauma therapists need support from community resources; they need supervision or consultation and a ‘sense of community’ or culture. They warn not to do trauma work in isolation.
9. Agencies that identify trauma as the primary issue of their client population respond with a supportive ‘culture’ that acknowledges and addresses secondary trauma stress and vicarious trauma.

Macro Level Discoveries

10. There is a need for more awareness, training, and cultural normalizing of STS and VT by the organization leaders within the trauma care systems.

Table 1

Participant Characteristics

Research Participant	Prof. Credentials	Age	Gender	Race/Ethnicity/Culture	Years of experience working with traumatized clients	Work setting	Trauma Population served	Supervision form/frequency	Current % of traumatized clients on caseload	# of Years Working with trauma in an Agency	# Years working with trauma in Private Practice	employment status working with trauma
1	LICSW	56	F	White	4	non profit outpt, FBS	homeless youth, families	group consultation/1 hr./wk., group/3 hrs./1x mo.	66	2	1	FT
2	LICSW	65	F	Caucasian/ItalianAmerican	40	outpt, private practice	MH, PTSD	ind. sup./hr/2x mo., group sup./1 hr/mo.	75	30	27	FT
3	LICSW	41	F	Caucasian	17	inpt, case management	corrections; adults	ind. Sup. 1x/week, groupsup 1.5-3 hrs/wk, consultation 1x/mo	95	17	0	FT
4	LICSW	65	F	Caucasian	35	International, national, local outpt	survivors of torture; adult, children, families	2 consultation groups/mo., (had 20 yrs of supervision, none now)	100	19	1.5	PT
5	LICSW	36	F	Caucasian	12	hospital	physical trauma; all ages, individuals and families	Team support and Unit member consultation as needed	80	12	0	FT
6	LICSW	40	F	Caucasian	17	foster care, inpt. psychiatric unit, residential	children and adults	Ind. Consultation/1-2 wk.	100	10	3	FT
7	LICSW	55	M	Caucasian	23	hospital outpt, private practice	PTSD, adults	ind. Sup. 1x/3rd wk, group consultation/wk, team support	20	23		FT
8	LICSW	60	F	Caucasian	23	outpt, private practice	complex traumatized children, adolescents	Ind. Sup./hr/2x mo., consultation group as needed	100	14	7	PT
TOTALS or AVERAGES	100% LICSW	Ave. age: 52.25	F=7, M=1	100% Caucasian	Ave. years of experience working with Trauma 21.375			Average amount of supervision/consultation on 1-2x mo. for 1-3 hrs. Individual and/or group	Ave. Current % of traumatized clients on caseload 79.5	Ave. # of Years Working with trauma in an Agency 15.875	Ave. # Years working with trauma in Private Practice 7	employment status working with trauma FT=6, PT=2

Note. Eight licensed clinical social worker that work with traumatized clients were interviewed for this research project. This table provides the raw data demographic information about the participants along with total and averages in the last row.

Table 2

Trauma Therapists have Similar Definition for STS or VT

Subthemes	Therapists comments
Therapist describe STS or VT when witness the enactment, pain, and experience the profound impact of trauma	<p>“I witnessed the enactment of the trauma; yelling, screaming, nasty to others.”</p> <p>“She sat in my office and flatly said the first time she was penetrated, she was very young, and by her biological father.”</p> <p>“Trauma is too much for your body to handle at that moment”</p> <p>“There is a spiritual, psychological impact from trauma”</p>
Therapists descriptors for the client’s trauma	<p>“Pervasive, painful, devastating, profound, gruesome, awful.”</p>
STS and VT requires the therapist application of emotional Regulation to intercept the impact of the trauma story	<p>“I envision a wall. The mantra that I use is ‘open heart, clear boundaries’, so I am trying not to take the energy in.”</p>

Note. Research findings were developed by first identifying subthemes from the common comments of the participants during the qualitative interview, then superordinate themes were identified which lead to the critical findings.

Table 3

Trauma Therapists are Self-Aware of STS or VT

Subthemes	Therapists comments
Therapist's notice a physical reaction in their body	"I feel a heaviness in the chest area" "I have an increase in heart rate" "I get teary"
Therapist feel an emotional reaction	"I feel sad, anxious, angry, irritable"
Occurs with the client	"Happen when the therapist is 'present' with the client"
Countertransference	"It's parallel to what is happening for the client." "Awareness is an important assessment tool. It's the window to see what is going on with the client." "It's how our clients get us to feel what they are feeling, to help us understand them and it helps me to figure out how to help my client" "a self-defense mechanism"
Awareness is a self-protector	"our defenses may get in the way and try to take us to other places, to disassociate, deny, oppress"

Note. Research findings were developed by first identifying subthemes from the common comments of the participants during the qualitative interview, then superordinate themes were identified which lead to the critical findings.

Table 4

Trauma Therapists have Similar Description of work with Traumatized clients

Subthemes	Therapists comments
Various Types of Trauma; single or complex trauma, human and nature perpetrators	“client was sexually abused, physically abused, tortured, ritualistically abused, neglected, abandoned, held captive, suffered car accident, attempted suicide, is paralyzed, witnessed violence”
Trauma is nondiscriminatory	“Trauma crosses all genders, age, and diversity.”
Trauma work can be a direct or indirect exposure to the traumatized client	“I help the patient the patient, family, and the team to cope with the psychological stress (of the trauma).” “It’s usually more than more than one thing; attachment and trauma”
Trauma often involves attachment	
Trauma can underlie acute and chronic mental illness	“I assess how people are struggling with acute stress symptoms or PTSD. I ask about nightmares and flashbacks” The client have a diagnosis of “PTSD, Personality disorder, ODD, Conduct Disorder and Emotional Disregulation.”
Trauma experiences are often linked with chemical substances	
Treatment is relational, Treatment is built on safety and trust Treatment teaches emotional regulation Treatment releases the trauma memory/pain Treatment often requires systems change Treatment may involve out of home placement for safety and self-regulation.	“Trauma needs to be released from the body” “Normalized their experience, identify the triggers, give permission to express anger/rage in appropriate way”

Note. Research findings were developed by first identifying subthemes from the common comments of the participants during the qualitative interview, then superordinate themes were identified which lead to the critical findings.

Table 5

Trauma Therapists have Similar Definition of Trauma

Subthemes	Therapists comments
Trauma is a whole person/whole body experience; impacts all senses	<p>“Trauma is your body’s means of protection”</p> <p>“Trauma is too much for your body to handle at that moment”</p>
Trauma is distress, negative, causing harm or loss	<p>“Trauma impacts a person in negative ways; impacts their sense of safety, their sense of being in this world, physically, psychologically, emotionally, and intellectually.”</p>
Trauma is an individualized experience	<p>“A person may not start out with an adequate amount of resilience or resilience may be built in.”</p>
Trauma is uncontrollable; there is a victim	<p>“Who would choose to be traumatized, you just are. There is no blame”</p>
There is a continuum of trauma; one time, repeated or chronic, simple or complex, low or high intensity	<p>“Type I us an unanticipated one-time trauma event, and Type II is ongoing, pervasive.”</p>

Note. Research findings were developed by first identifying subthemes from the common comments of the participants during the qualitative interview, then superordinate themes were identified which lead to the critical findings.

Table 6

Micro Practice Resources: Self Care is a Trauma Therapist's Armor

Subthemes	Therapists comments
Practice Balance	<p>"I separate work from rest of life"</p> <p>"I talk with friends about things not connected to work"</p> <p>"There were a few years I was burnout. I was barely operating; it was work to get out of bed. I thought I was depressed, but it was compassion fatigue. This is when I was doing foster care with traumatized kids and lived with their stuff, day in and day out"</p> <p>"get food sleep, eat healthy"</p>
Get absorbed in enjoyable activities	<p>"I watch sports or read fiction,"</p> <p>"I watch a silly TV show"</p> <p>"I spend time with my friends and family"</p>
Release the stress from your body	<p>"I talk with colleagues"</p> <p>"I exercise", "I take long walks"</p> <p>"I attend to my physical/medical needs"</p>
Release the trauma from thought	<p>"I focus on a positive perspective."</p> <p>"I let it go; I did the best I could."</p>
Manage it in the moment, in client session	<p>"I practice mindfulness skills"</p> <p>"I practice grounding techniques"</p> <p>"I learned and practice energy work and visualization"</p>

Notes. The information for this table was derived from eight LICSW clinicians that have been working with traumatized clients for an average of 23 years.

Table 7

Meso and Exo Level Recommendations for STS and VT

Recommendation	Therapists comments
Train the supervisor, administration, and agencies About STS and VT	<p>“Supervisors of trauma therapy need to attend specific trainings about how to supervise a therapist working with traumatized clients”</p> <p>“We need administration that are trauma informed; aware of the impact of working with trauma”</p> <p>“We need agencies the provide “training on STS and VT” and “pay for trainings on STS and VT”</p> <p>“get food sleep, eat healthy”</p>
Develop trusting relationships between trauma Therapists and supervisors, and administration	<p>Supervisors need “to build a trusting relationship” with their supervisees</p> <p>“Administration focus on funds, don’t care about therapist”</p>
Build skills in the clinical supervisor of trauma therapists	<p>Supervisors need the “ability to check in about it (STS and VT); to see and address the hurt in therapist”</p> <p>“We need supervisors that are doing their own self-care”</p>
Build an agency culture that recognizes, normalizes, and expects STS and VT	<p>“Agencies need to have an open environment”, “safe, compassionate culture”</p> <p>“Agencies that offer health care benefits and time off”</p>

Notes. The information for this table was derived from eight LICSW clinicians that have been working with traumatized clients for an average of 23 years.

Table 8

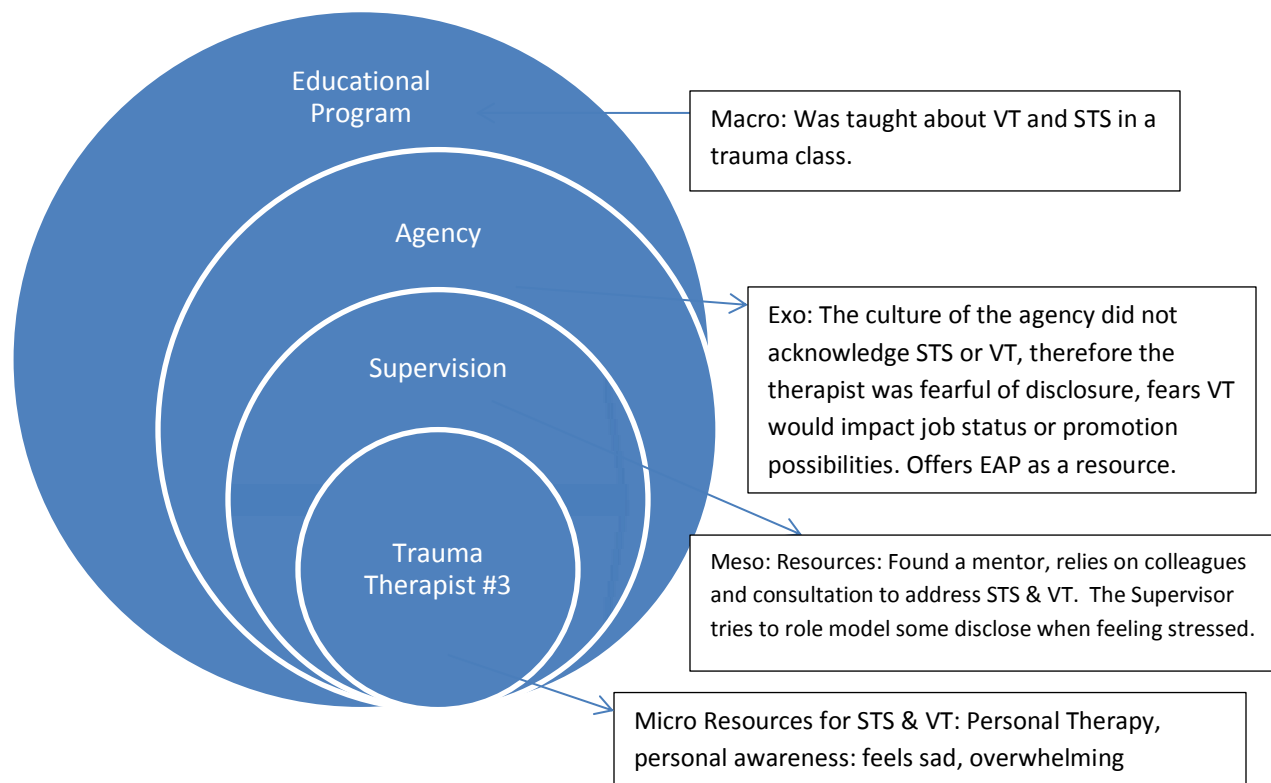
Macro Level Recommendations for STS and VT

Recommendation	Therapists comments
Normalize STS and VT	“self-disclosure; talk about it, normalize it, make it (STS/VT) common language”
Provide training specific to normalizing and expecting STS and VT to occur when working with trauma	“Provide more training on countertransference” Teach " you don't have to carry another person's burden and teach how to do that”
Broaden the scope of thinking about trauma	“Promote prevention of abuse” “Insurance companies need to be trauma informed, including information on therapy options for complex trauma”

Notes. The information for this table was derived from eight LICSW clinicians that have been working with traumatized clients for an average of 23 years.

Figure 1:

Example of ecological mapping of interviewee information in research field notes.



Notes. An ecological mapping of each interview was completed by the researcher to gain a systems perspective. The ecological mappings were reviewed during data analysis and considered collaborating evidence to support the subtheme and superordinate themes found in the interviews with trauma therapists.

Figure 2.

Ecological Framework

Note. This figure identifies the systems considered at each ecological level for this study.